Volume 1

The Therapeutic Relationship in Cognitive-Behavioural Therapy for Psychosis: The Role of Client, Therapist and Therapy Factors.

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D.Clin.Psy 2004

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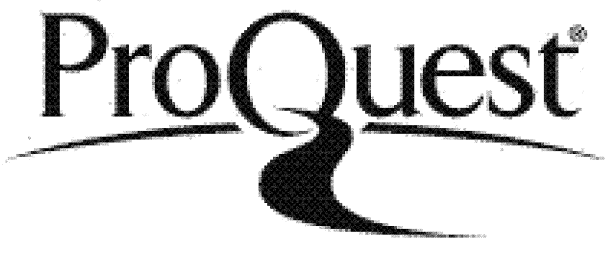

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ABSTRACT

The study investigated which client, therapist, and therapy characteristics were associated with the quality of the therapeutic relationship in Cognitive-Behavioural therapy (CBT) for psychosis. The development of a good therapeutic relationship is essential to the work of CBT for psychosis but is often more difficult to achieve due to the nature of psychotic symptoms. Despite this, there has been little research investigating what affects the development of the therapeutic relationship within CBT for psychosis.

The study had a cross-sectional, correlational design with measures taken at around the sixth session of therapy. Clients and therapists completed questionnaires measuring client, therapist, and therapy factors, and their perceptions of the therapeutic relationship.

On average, both clients and therapists rated the therapeutic relationship as good. Although there was a trend towards agreement on the quality of the therapeutic relationship, on average clients rated it higher than therapists. There were few significant effects of client or therapist factors on the therapeutic relationship, including some unexpected negative results, e.g. no effect for psychotic symptoms. There were some significant effects for therapy factors and clients reports of the therapeutic relationship, e.g. the presentation of a case formulation.

ACKNOWLEDGEMENTS

I would like to thank Dr Chris Barker for his excellent advice and continued encouragement and positive outlook, and Dr Emmanuelle Peters for providing invaluable practical support and advice.

A big thank you must go to my friends and family for believing in me and telling me so when I most needed to hear it!

And of course, most importantly, this research couldn't have taken place without the participation of the therapists and clients – Thank you.

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CHAPTER 1

INTRODUCTION

Between 25% and 50% of patients with schizophrenia have residual psychotic symptoms, despite optimal pharmacological intervention (Kane & Marder, 1993). The resulting social disability is likely to persist throughout their adult lives (Bustillo, Lauriello & Keith, 1999). As a result, psychological ways of intervening with psychosis have been developed in an attempt to treat these residual symptoms. Cognitive-behavioural therapy (CBT) is one such treatment. CBT has been found to reduce psychotic symptoms, and this reduction is sustained over time (e.g. Gould, Mueser, Bolton, Mays & Goff, 2001).

A good therapeutic relationship is likely to be more difficult to establish with psychotic clients due to the nature of their presentation and past experiences, e.g. clients may not trust and/or hold delusional beliefs about their therapist whilst therapists may find it difficult to empathise with clients' unusual experiences. However, a good therapeutic relationship is crucial to the work of CBT for psychosis (e.g. Fowler, Garety & Kuipers, 1995). Despite this, little research has been conducted to date to investigate the correlates of the therapeutic relationship, examining client, therapist and therapy factors in CBT for psychosis. This study will therefore begin this process.

The chapter will begin by reviewing the two separate areas of: cognitive-behavioural therapy for psychosis, and the therapeutic relationship. It will discuss why the therapeutic relationship is considered to be important in CBT for psychosis, but also

likely to be more difficult to establish. Research will be presented which suggests which factors may be important in predicting the therapeutic relationship in CBT for psychosis. Finally, the rationale and research questions for the present study will then be presented.

1.1 COGNITIVE-BEHAVIOURAL THERAPY FOR PSYCHOSIS

Research has found that CBT consistently reduces psychotic symptoms, with results sustained or even improved at one-year post-treatment (Garety, Kuipers, Fowler, Chamberlain & Dunn, 1994; Kuipers, Garety, Fowler, Dunn, Bebbington, Freeman & Hadley, 1997; Sensky, Turkington, Kingdon, Scott, Scott, et al., 2000; Tarrier, Kinney, McCarthy, Humphreys & Wittowski, 2000, Tarrier, Yusupoff, Kinney, McCarthy, Gledhill et al., 1998). Other benefits have been a reduction in days in hospital (Tarrier, Harwood, Barker, Yusupoff & Ugarteburu, 1993), in negative symptoms (Tarrier et al., 1998) and in depression (Garety et al., 1994). The first meta-analysis of the effects of CBT for psychosis found an effect size of 0.65 for reduction of psychotic symptoms across seven controlled studies. These effects were robust over time (Gould et al., 2001).

CBT for psychosis differs from CBT for other psychiatric problems, in that is combines a number of models, takes a more flexible and individualised approach, takes longer, and emphasises engagement and the therapeutic relationship. The cognitive approach of Beck and colleagues (e.g. Beck, 1976) is combined with cognitive models of psychotic symptoms, and stress-vulnerability models of schizophrenia. A number of therapists have adapted CBT for psychosis, e.g.

Chadwick, Birchwood and Trower (1996), Fowler, Garety and Kuipers (1995), Kingdon and Turkington (1994) and Nelson (1998).

Therapists begin by working from the perspective of the client and the client's model and understanding of their difficulties. This is likely to differ from approaches other mental health professionals have taken with the client. The engagement period is likely to last for up to six sessions or more, which is longer than would be expected when working with non-psychotic clients. Psychoeducation is used to reduce stigma and increase normalisation of symptoms. Once a good therapeutic relationship has been established the therapist then helps the client understand better the processes which affect their thoughts and feelings. The aim is for clients to be able to re-evaluate their views of themselves and the psychosis in order that the distress and impairment in functioning associated with the psychotic symptoms is reduced (Garety, Fowler & Kuipers, 1995). As the reduction of distress and disability is the primary goal of therapy, this may mean that some aspects of psychotic symptoms, e.g. the level of conviction in delusions, do not change, and indeed do not need to change, in order for this goal to be reached. Clients with psychosis often present with secondary emotional disturbances and these symptoms can be targeted using the same CBT model and approach. Within the CBT model, it is hoped that clients will come to learn that their beliefs are hypotheses and not facts. This knowledge should then allow clients to re-evaluate their beliefs and as a result reduce their distress. For example, a client who believes they are being persecuted by their neighbours would come to view this belief as a hypothesis to be tested. By doing so, they may begin to believe that it is unlikely their neighbours are persecuting them and so feel less

angry, anxious etc. Overall, it is hoped that psychotic and affective symptoms will reduce, as well as the probability of future relapse.

This process involves client and therapist conceptualising a delusion as a belief and not a fact, in order that gentle and collaborative challenging of the delusion can take place. Such is the nature of psychosis, that beliefs are often very resistant to change, particularly in response to direct challenging (Milton, Patwa & Hafner, 1978). Clients are likely to have experienced other people, including mental health professionals, as dismissive and possibly directly challenging of their beliefs. Clients are therefore likely to be alert to new people, including their therapist, also approaching them and their beliefs in this way. In CBT for psychosis the client is viewed as rational and their delusions as explanations of their often unusual experiences, e.g. auditory hallucinations. This aids the development of a good therapeutic relationship where the client feels their therapist understands why they hold their beliefs. Therapist and client can then work collaboratively to reduce the negative impact of these beliefs on the client's everyday life.

In summary, CBT for psychosis has recently been developed in order to treat clients with residual psychotic symptoms and has been found to be effective at doing so. Because of the nature of psychosis, a good therapeutic relationship is crucial in order that the work of CBT can be carried out.

1.2 THE THERAPEUTIC RELATIONSHIP

In order to investigate the therapeutic relationship it is essential to understand the meaning of the concept. This can best be done within a historical context, where the concept has been developed and researched with non-psychotic clients. A good summary can be found in Horvath and Bedi (2002).

1.2.1 The Psychoanalytical Approach

Consideration of the therapeutic relationship originated within psychoanalytic theory. Freud first wrote about the therapist-client relationship. He divided it into two parts: the neurotic aspects of the client's attachment to the analyst (transference) and the friendly and positive feelings that the client has toward the therapist which are grounded in reality. He believed that the positive and reality-based part of the relationship led to a therapeutic partnership against the common foe, the client's neurosis (Freud, 1958).

Greenson (1967) developed this idea, labelling the rational rapport developed between analyst and patient as the "working alliance" and viewing it as an essential component of successful therapy, because it allows the client to "work with the analyst despite the neurotic transference reactions" (Greenson, 1967, p29).

1.2.2 Rogers' Therapist Offered Conditions Approach

A different view of the function of the therapeutic relationship was put forward by Carl Rogers in 1957. He suggested that the relationship was an agent of change in itself. In order to establish such a therapeutic relationship, therapists need to be empathic, congruent and have unconditional positive regard toward the client

(Rogers, 1957). Within this model, it is the role of the therapist to develop the therapeutic relationship. The ability and motivation of the client to make use of Rogers' therapist offered conditions is not taken into account. Later writers have concurred with Rogers' model, e.g. Barrett-Lennard (1962), Henry and Strupp (1994).

1.2.3 Strong's Social Influence Theory

In 1968, Strong put forward a social influence theory of the therapeutic relationship, describing the therapeutic relationship as being useful in influencing clients' behaviour in therapy. He proposed that the greater the extent to which therapists are perceived as expert, attractive, and trustworthy, the greater is their credibility and therefore their power to influence clients. The therapeutic relationship therefore is viewed as useful only in enhancing compliance with therapy.

1.2.4 Bordin's Pantheoretical Approach

Following on from Greenson (1967), Bordin (1979) developed a model of the working alliance that was pantheoretical, i.e. applicable to all types of therapy. It also differed in that it emphasised the roles and responsibility both the therapist and the client have in developing the working alliance. He divided the therapeutic relationship into three factors –agreement on the *goals* of therapy, collaboration on therapeutic *tasks,* and the interpersonal *bond* between client and therapist. A mutual understanding and agreement about the change goals of therapy and the tasks required to meet those goals is mediated by the presence of a bond between patient and therapist to maintain the work. When there is a strong working alliance, the therapist and client mutually endorse and value the goals that are the target of

therapy, both see the therapeutic tasks as relevant and efficacious and accept their responsibility to carry them out, and there is a positive personal attachment between the client and therapist.

The Working Alliance Inventory (WAI: Horvath, 1981) was devised to measure the working alliance according to the three components of Bordin's (1979) model of the working alliance: goals, tasks and bond.

1.2.5 The Role of the Therapeutic Relationship in Therapy

Bordin further developed the role of the working alliance, viewing it not as an agent of change in itself, but rather as what allows the client and therapist to work collaboratively against the problem of the client's pain. He viewed it as a necessary but not sufficient condition for therapeutic techniques to work, facilitating other aspects of the change process (Raue & Goldfreid, 1994). Bordin differentiates between the building of the therapeutic relationship, and the process of maintenance which follows. In the building phase, agreement on goals is key. The process of negotiating the goals allows the bond to develop and from a good understanding of the goals, agreement and commitment to tasks will follow. The bond takes longest to develop, becomes stronger over time, and is more important in maintaining a good therapeutic relationship. It allows the therapist and client to overcome the inevitable strains and ruptures in the therapeutic relationship in relation to goals, tasks or bonds. Working through these strains or "ruptures" (Safran & Muran, 1996) is deemed to be therapeutic, as they allow opportunities for observation and exploration of the client's difficulties and may provide a corrective emotional experience (Safran, 1993).

This view of the therapeutic relationship differs from Rogers' where it is an agent of change in and of itself, and from Strong's where it enhances compliance. These competing views have generated a significant amount of research. Reviews of the research suggest that both the therapist and the client have a role in developing the therapeutic relationship (Horvath & Luborsky, 1993) and that the therapeutic relationship provides only one part of the factors involved in successful therapy (e.g. Gelso & Carter, 1985). Strong's persuader variables have been found to serve only as a basis for facilitating the therapeutic relationship and are not necessarily a direct contributor to change (Beutler, 1978). These findings support the theoretical view held by Bordin (1979) that the therapeutic relationship is a necessary but not sufficient aspect of therapy and that both therapist and client have a role to play in its development. Following on from this, research has attempted to discover what therapist and client factors contribute to the development of a good therapeutic relationship.

1.2.6 Factors Which Predict the Therapeutic Relationship

There is disagreement about whether client or therapist factors impact more on the therapeutic relationship. Therapists report that clients' contributions are more important, whereas clients claim that therapist attributes contribute more to the development of the therapeutic relationship (e.g. Bachelor, 1991; 1995; Lambert & Bergin, 1983).

Therapist Factors

A recent review by Ackerman and Hilsenroth (2003) examined the therapist attributes and therapist interventions that positively impact on the therapeutic relationship across a range of psychotherapy approaches. They found that to produce

a good early therapeutic relationship therapists needed to convey a sense of being trustworthy; to be affirming, flexible, confident, warm, respectful, experienced and competent; and to use affiliative behaviours. Another review concurred with these findings (Lambert & Barley, 2002). Ackerman and Hilsenroth (2003) proposed that these therapist factors enabled clients to believe that their therapist could understand them and help them with their difficulties.

Moreover, the attributes of empathy, trustworthiness and expertness have been found to be significantly related to the bond scale of the WAI (Horvath & Greenberg, 1989). Therapists with more training and experience have been found to have higher scores on the task and bond scales of the WAI (Mallinickrodt & Nelson, 1993).

Client Factors

However, patient involvement has been found to be a stronger predictor of the therapeutic relationship than therapist attitudes or techniques (Windhohl & Silbersatz, 1988). Patient involvement can be broken down into participation, commitment and working capacity. Defensiveness and hostility impact negatively on the therapeutic relationship (Gaston, Thompson, Galllagher, Cournoyer & Gagnon, 1998; Muran, Segal, Samstag & Crawford, 1994;). Clients who have had more service contacts and display less severe symptoms have been found to develop better therapeutic relationships (Clarkin & Crilly, 1987; Klinkenberg, Calsyn & Morse, 1998). Client factors found *not* to impact on the therapeutic relationship are: distress, depression, Axis II disorders (De Rubeis & Feeley, 1990) and gender (Horvath, 1994).

It may also be that pretherapy characteristics of both the therapist and client may impact on the therapeutic relationship, e.g. those with more secure early attachments form better therapeutic relationships (Bachelor & Horvath, 1999).

Congruence on Client and Therapist Demographic Variables

Studies with non-psychotic clients have found that certain types of client-therapist pairings on a number of demographic variables are more effective than others. Demographic similarity between client and therapist in terms of age, ethnicity, gender and socio-economic background facilitates positive perceptions of the relationship in the beginning stages of treatment (Blasé, 1979; Jones, 1978; Luborsky et al., 1983). In terms of the client's perception of the therapeutic relationship, gender and ethnicity similarity in particular increases their perception of therapists as empathic, increases their liking of the therapist, and the therapeutic relationship is judged more helpful. It is hypothesised that this is because clients use obvious similarities to establish a basis for trust and for assessing how likely they are to be understood (Beutler, Clarkin, Crago & Bergan, 1991).

Therapeutic Tasks

In addition the contribution of client and therapist factors, different therapeutic interventions have been found to impact on the development of the therapeutic relationship, e.g. the presentation of a case formulation, the depth of a session. Ackerman and Hilsenroth (2003) found that techniques which conveyed support, increased clients' understanding of their difficulties, and increased the level of connection between therapist and client all helped produce good early therapeutic relationships. Adherence to, but not the amount of, techniques impacted positively on

the therapeutic relationship in psychodynamic therapy (Ogrodniczuk & Piper, 1999). They hypothesised that these techniques increased clients' understandings of their difficulties and demonstrated the usefulness of treatment for these difficulties.

1.2.7 The Therapeutic Relationship in CBT

Within the cognitive-behavioural approach, the technical aspects of treatment were initially emphasised over and above any consideration of the therapeutic relationship. However, in 1976 Beck first described the "collaborative empiricism" between client and therapist that is now considered crucial to the success of a CBT approach (e.g., Raue & Goldfried, 1994). Without a good therapeutic relationship, cognitive therapy may become "gimmick oriented" (Beck, Wright, Newman & Liese, 1993, p.135). Using Bordin's (1979) model of the working alliance, the goals of therapy are likely to be explicitly stated problem areas and the tasks are likely to be prescribed. The bond will vary according to the nature of the tasks, e.g. a deeper level of trust will be required when the client recounts painful events. The cognitive-behavioural view of the role of the therapeutic relationship in therapy is in accordance with Bordin's, i.e. it is a necessary but not sufficient condition for change. More specifically, it is viewed as a reinforcer when technical interventions cannot provide rapid rewards for clients (Beck & Freeman, 1990), as facilitating clients' engagement in the tasks of therapy, and as preventing or overcoming resistance (Gelso & Carter, 1985). To date, two studies have found higher ratings of the therapeutic relationship in CBT than in Psychodynamic therapy (Raue, Castonguay & Goldfried, 1993; Stiles, Agnew-Davis, Hardy, Barkham & Shapiro, 1998), although it has been proposed that the strength of the bond may not be as deep as it is with other orientations because sessions may arouse fewer emotions in clients.

Research investigating the impact of client and therapist factors in CBT has found that therapists who increase the structure of therapy sessions, either enhanced or brought about a positive therapeutic relationship (Alexander et al., 1976) and that the higher the client's score on the global assessment of functioning (GAF: Endicott, 1976), the better the therapeutic relationship (Raue et al., 1993).

1.2.8 The Therapeutic Relationship and Outcome

Lambert and Bergin (1994) have argued that the therapeutic relationship accounts for "most of the gains" from psychotherapy interventions with non-psychotic clients. In a meta-analysis, Horvath and Symonds (1991) supported this view when they found there to be a reliable moderate relationship between the working alliance and outcome in psychotherapy. More recent meta-analyses have also supported this finding (Martin, Garske & Davis, 2000). These studies have measured the therapeutic relationship from different perspectives (client, therapist, observer) and across different populations and therapeutic approaches. When pre-therapy scores are controlled for statistically, the alliance predicts on average 21% of the outcome variance (Horvath & Bedi, 2002). Therefore, the therapeutic relationship is not solely a by-product of therapeutic gains, but a factor in therapy in and of itself.

The early therapeutic relationship has been found to be a significant predictor of outcome, with the later therapeutic relationship a more modest predictor. Studies suggest there to be a "window of opportunity" in sessions three to five (e.g. Mohl, Martinez, Ticknor, Huang & Cordell, 1991, Plotnicov, 1990; Tracey, 1986). Those clients who do not develop a good therapeutic relationship early on and fail to agree

on the goals of therapy are more likely to disengage from therapy either by dropping out or by not engaging in the necessary work of therapy, that is the tasks.

When asked to rate the therapeutic relationship, agreement between client and therapist is low in the early stages of therapy(Golden & Robbins, 1990; Horvath & Marx, 1990). At this stage in therapy it is the client's assessment of the therapeutic relationship which better predicts outcome (Horvath & Symonds, 1991; Lambert & Bergin, 1994).

In summary, the concept of the therapeutic relationship has been developed over time from different theoretical positions. Bordin's (1979) model of the working alliance is pantheoretical and can be measured using the Working Alliance Inventory (Horvath, 1981). Research with non-psychotic clients has found that the therapeutic relationship is a necessary but not sufficient aspect of therapy and that it is the early therapeutic relationship, particularly the client's view of it, that predicts outcome in therapy.

1.3 THE THERAPEUTIC RELATIONSHIP IN CBT FOR PSYCHOSIS

1.3.1 The Therapeutic Relationship and Clients with Psychosis

As early as Rogers in 1967, research has shown that psychotic clients were less likely to form good therapeutic relationships with their therapists. An early study found that only five out of fifteen therapists of psychotic clients thought that even weak alliances had been formed after two years of treatment (Grinspoon, Ewalt & Shader, 1972). More recently, Frank and Gunderson (1990) found that at six months, only 41% of therapists rated the therapeutic relationship as either "fair" or "good".

However, this study made use of unusual outcome measures and had a heterogeneous sample. From studying the development of the early therapeutic relationship Frank and Gunderson (1990) concluded that with psychotic clients it is still developing during the first six months of treatment. This is as opposed to the early therapeutic relationship with non-psychotic clients which is assumed to develop after only a few sessions (e.g. Mohl et al., 1991; Plotnicov, 1990; Tracey, 1986). In terms of services, historically clients with psychosis have engaged poorly (Drake, 1998; Minkoff & Stern, 1985).

A more recent study which involved psychotic clients who had been screened for their level of motivation to engage and were receiving cognitive therapy twice a week in a psychiatric hospital, reported higher levels of good therapeutic relationships (Svensson & Hanson, 1999). In the initial phase of cognitive therapy, 96% of clients and 89% of therapists reported either "fair" or "good" therapeutic relationships. However, this study had a number of methodological limitations, namely a small sample, lack of a measure of treatment adherence and an unusual treatment setting. A second study (Dow, 2003) found that overall, levels of empathy, working alliance and affective responses from both clients and therapists were good. Both observer ratings of the working alliance and client ratings of therapist empathy were significantly positively skewed with many clients selecting the maximum score on many items. The working alliance was measured using the observer form of the WAI and a good therapeutic relationship was found to be often present. This is comparable to Raue, Castonguay and Goldfried's (1993) findings that for expert therapists working with anxious or depressed clients good therapeutic relationships were very often present. Dow (2003) found that the bond scores were highest,

followed by tasks, and goals. All were highly correlated. Clients also rated therapist empathy significantly higher than therapists. These findings of high levels of working alliance, empathy and affective response and were not expected and Dow considers whether they were made more likely because the therapists in the sample were considered experts, clients rated the working alliance and therapist empathy in front of their therapist, and all measures were taken in the first session when therapists may be more likely to work in such a way as to engender a positive first session in order to encourage clients to return.

Taken overall, these studies suggest that it is not possible to make conclusions about the difficulty of engaging clients with psychosis. Earlier studies suggested engagement may be more difficult and take longer with clients with psychosis whereas more recent research has found good levels of therapeutic relationship comparable to non-psychotic populations, and many of the studies are methodologically flawed and vary in terms of treatment approach, setting and clients.

There are a number of reasons why developing a good therapeutic relationship may be more difficult with psychotic clients. Psychotic symptoms may impact on a number of areas: (1) how the client views their therapist, (2) agreement on goals and tasks of therapy, (3) the ability of the client to undertake the tasks of therapy, (4) whether the therapist can understand and empathise with the client, and (5) feelings the therapist may have about the client and about the likely outcome of therapy (e.g. Chadwick, Birchwood & Trower, 1996; Fowler, Garety & Kuipers, 1995).

The client's view of their therapist

There is an increased likelihood of difficulties establishing a relationship with psychotic clients because their symptoms may adversely affect their view of the therapy, e.g. they may develop paranoid beliefs about the therapist (Fowler et al., 1995). Clients may also be mistrustful of therapists and unwilling to disclose problems because of their past experiences with mental health services and their view of the therapist as part of that system. Clients may have been sectioned against their will, making services seem controlling and untrustworthy. In addition to this, clients may have learnt that disclosing problems leads to things happening which they do not want, e.g. increases in medication, sectioning. Therapists must pay more attention to the therapeutic relationship than in other CBT approaches in order to address these problems, e.g. addressing delusional beliefs about the therapist and other beliefs about the effects of disclosing information.

Agreement on goals and tasks

As it is the development of, and agreement on, goals which is the first aspect of the alliance to develop, it may be this area which is in some way more difficult with psychotic clients. Clients may come to therapy with models and views on the nature and origin of their difficulties and therefore, opinions on how to approach those difficulties that are different from their therapists'. This is because psychotic clients are likely to display little of what is termed "insight" into their difficulties – i.e. an awareness that their difficulties may be a mental illness. Whereas the therapist's goal for therapy may be some sort of change in the client's delusion, e.g. in conviction or preoccupation, this may not be what the client initially wants from therapy. The nature of their psychotic symptoms means that they may want their therapist to help

them with an aspect of their delusion that they believe to be real and the cause of their problems, e.g. help to stop the FBI bugging their house. Therapists work from the client's perspective in order that an agreement on the goals of therapy can be reached, i.e. that it is a reduction in the client's distress that is crucial. This human response is seen by Chadwick, Birchwood and Trower (1996, p.39) as "the bridge in CBT for psychosis that enables client and therapist to work on agreed goals". Therapists must then establish a common understanding of what is causing the client's distress and so socialise the client into the cognitive model, i.e. it is their beliefs about their experiences which causes their distress, not their experiences per se. If such a joint understanding of why the client experiences distress cannot be reached, it is likely that the therapist and client will also not agree on the tasks of therapy, e.g. the client may wish to focus on debugging their house, whereas the therapist may want to look for evidence for and against the client's belief that their house is bugged. Client and therapist agreeing on the goals and subsequent tasks of therapy is therefore more likely to be difficult with psychotic clients who display little insight into their condition. As stressed by Fowler, Garety and Kuipers (1995), it is therefore crucial for therapists to monitor that the client's concerns are being addressed in order that they do not disengage from therapy.

Ability of the client to undertake the tasks of therapy

Cognitive deficits associated with psychosis, e.g. a reduction in attention, memory and concentration, may mean clients find it more difficult to carry out the tasks of therapy. Therapists need to be aware of this and be flexible in sessions, e.g. shorter sessions, repeating information and summaries.

Ability of the therapist to empathise with the client

Psychotic clients experience fundamental distortions of perception and thinking and this may mean therapists find the clients' experiences difficult to understand. They have been seen as the "non-understandable" symptoms within mental health (Jaspers, 1968), although increasingly psychotic symptoms are being seen less as fundamentally distinct from normal processes, and more as extreme manifestations of normal phenomena (Costello, 1992; Fowler, Garety & Kuipers, 1995). Other psychotic symptoms such as thought disorders and inappropriate affect may make the client's speech and presentation hard for the therapist to understand.

Feelings of the therapist

Engaging with psychotic clients may be disturbing for therapists (Fowler, Garety & Kuipers, 1995) and they may become overwhelmed by the bizarre and disturbing nature of psychotic experience and by the associated disability. Clients' behaviour may contravene social norms and lead to feelings of hopelessness, frustration or anxiety in professionals as much as in the general population (McLeod, Deane & Hogbin, 2002). Therapists may then withdraw emotionally from such "difficult" clients (e.g. Ginsberg, 2000; Hinshelwood, 1999). Therapists may also be affected, consciously or not, by the pessimism and despair associated with the treatment of psychosis, which is in some way justified by the fact that outcome for the most severe psychoses is worse than that for affective disorders, in terms of psychopathology and negative social consequences (Marneros, Deister & Rohde, 1992). Therapists need to be able to "accept the possibility of levels of untreatable disability and seek guidance and support on what is likely to be achieved" (Fowler,

Garety & Kuipers, 1995, p.75) and also have an interest in, and capacity to tolerate, intense affect, dependency and ambiguous communication (Fenton, 2000).

1.3.2 Factors Associated With a Good Therapeutic Relationship

To date, only three studies have investigated which client, therapist and therapy characteristics are associated with a better therapeutic relationship for clients receiving CBT for psychosis. Svensson and Hansson (1999) found few significant correlations between client characteristics (age, gender, onset age, length of illness, number of previous inpatient admissions, number of suicide attempts, global functioning, and quality of life) and the working alliance but did find that those clients more likely to form a good therapeutic relationship were those who presented with more complaints, a more severe level of symptoms, more pre-admission social relationships and work, and fewer days spent in hospital in the last eighteen months.

Dow (2003) investigated which client and therapist demographics (age, gender, marital status, and years qualified), client symptoms (anxiety, depression, positive and negative psychotic symptoms, hallucinations and delusions), and client baseline characteristics (length of illness, psychiatric admissions in the past year, and history of violence, sexual offences, suicide attempts, and prison sentences) impacted on the working alliance, therapist empathy, and therapist affective response. There were few significant relationships between these factors; only clients with a history of violence had poorer levels of working alliance, although the differences in scores were small. This may in part have been due to a small sample size and low variance in working alliance scores.

Other studies have investigated psychotic clients who are receiving types of therapy other than CBT for psychosis. Clients who had experienced their first episode of psychosis were found to have poorer therapeutic relationships than more chronic clients (Fleischhacker, 2002). Two other studies found that psychotic clients whose symptoms were more severe (McCabe & Priebe, 2003) and who had had fewer hospitalisations (Allen, Deering, Buskirk & Coyne, 1988; Frank & Gunderson, 1990) were more likely to form better therapeutic relationships.

In terms of therapy factors, it has been found that presenting a case formulation in CBT for psychosis does not impact on clients' nor therapists' ratings of the therapeutic relationship, although in qualitative interviews clients said the case formulation helped increase their understanding and optimism (Chadwick, Williams & Mackenzie, 2003). Furthermore, the therapeutic relationship was measured for only two sessions after presentation of the case formulation and therefore there may not have been sufficient time for the effects to emerge.

In summary, a few studies have begun to investigate what client, therapist and therapy factors predict the therapeutic relationship for clients with psychosis. All have studied different factors and in different treatment settings. Therefore, no firm conclusions have yet been reached.

1.3.3 CBT for Psychosis Outcome Research

It has been shown that the therapeutic relationship predicts a significant proportion of outcome, both for psychotic and non-psychotic populations (e.g. Bachelor & Horvath, 1991; Bentall, Lewis, Tarrier, Haddock, Drake & Day, 2003). Therefore,

those factors which have been found to predict outcome in CBT for psychosis may do so through the therapeutic relationship, i.e. the therapeutic relationship may mediate the effect these factors have on outcome. Therefore, it is relevant to the present study to consider those factors which predict outcome in CBT for psychosis. However, so far few studies have been conducted in this area and those that have differ on important factors such as length and type of CBT, and types of clients and so currently it is difficult to make any firm conclusions.

Client factors found to predict outcome in CBT for psychosis are: stable and persistent symptoms (NICE, 2003), the number of inpatient admissions (more), insight into social consequences (more) (Kuipers et al., 1997); gender (female), duration of untreated illness (shorter), time elapsed since first psychotic episode (shorter), (Drury, Birchwood, Cochrane & MacMillan, 1996), entertaining "the possibility of being mistaken" (Kuipers et al., 1997; Jakes, Rhodes & Turner, 1999; Chadwick & Lowe, 1994) and cognitive insight (Granholm et al., 2002). There have been contradictory findings in regards to the level of initial psychopathology (Tarrier et al., 1993; 1998; Kuipers et al., 1997). Clients who only presented with negative symptoms and no distress were less likely to benefit from CBT for psychosis (Fowler, 1992). Factors not related to outcome in CBT for psychosis are: premorbid IQ, age of illness onset, affective symptoms, demographic characteristics and strength of delusional conviction (Kuipers et al., 1997; Jakes, Rhodes & Turner, 1999).

1.3.4 The Therapeutic Relationship and Outcome for Clients with Psychosis

More recently, studies have begun to investigate the relationship between the therapeutic relationship and outcome in therapy with people with psychosis. One

reason for this interest is recent findings that post-therapy levels of client outcome are comparable between CBT for psychosis and other, non-specific therapies, suggesting that non-specific factors may account for a significant proportion of outcome with this client group (e.g. Tarrier et al., 2000). A recent randomised control trial has found that across a number of treatment conditions for people with psychosis patient ratings of the therapeutic relationship at the end of the fourth session predicted positive symptoms and general psychopathology, but not negative symptoms, at eighteen-month follow-up (Bentall et al., 2003). Therapist ratings of the therapeutic relationship did not predict outcome. Other studies with psychotic populations have found that the early therapeutic relationship as rated by therapists predicts drop-out rates, medication compliance rates, and gains in clinical outcomes (Frank & Gunderson, 1990, Svensson & Hanson, 1999), but that patient ratings of the therapeutic relationship do not (Svensson & Hanson, 1999). This result is similar to Neale and Rosenheck's (1995) finding that case-manager-rated therapeutic relationships predicted outcome in a study of assertive community treatment for a patient group where 71% had schizophrenia. Yet another study has found that although the client and therapist ratings of the early therapeutic relationship were correlated and both predicted outcome, therapist ratings did more so (Gehrs & Goering, 1994). Therefore, studies suggest that the therapeutic relationship predicts outcome in CBT for psychosis, although there is not agreement on whether the client or therapist's rating does so better

Qualitative reports and studies also highlight the importance of the therapeutic relationship. Fowler, Garety and Kuipers (1995, p.163) report that "patients have said that willingness to change their beliefs derived, not from what was said, but rather

from the development of trust with the therapist". Chadwick and Lowe (1994) in their multiple single case design report that all their participants undergoing CBT for psychosis talked about the importance of a good therapeutic relationship which allowed them to discuss their beliefs without being judged or criticised. In a qualitative study of clients' experience of CBT for psychosis most participants described the therapeutic relationship as collaborative and as a "respectful relationship between equals". Therapy was viewed as an opportunity to discuss their problems openly with a genuinely interested and empathic person who took their experiences seriously (Messari & Hallam, 2003, p.183).

In summary, research findings agree with clinical opinion that it may be more difficult to establish a good therapeutic relationship with psychotic clients. Doing so may take a lot longer, e.g. six months. It is hypothesised that psychotic symptoms such as paranoia and distortions in perception contribute to this difficulty, as do therapist factors such as pessimism about outcome when working with people with psychosis. Initial findings suggest the therapeutic relationship predicts outcome in CBT for psychosis, although there are mixed views about which is the stronger predictor – client or therapist ratings. To date, only a few client and therapist factors and one therapy factor have been studied that might predict the therapeutic relationship. The next stage in research with this client group is therefore to consider what factors previous research can suggest will affect the quality of the therapeutic relationship.

1.4 FACTORS TO BE STUDIED

From the various areas of research, there are suggestions as to how each client, therapist and therapy factor might affect the therapeutic relationship in CBT for psychosis.

1.4.1 The Early Therapeutic Relationship

Previous research with clients with psychosis is in disagreement over whether the therapeutic relationship is of a poorer quality when working with clients with psychosis (e.g. Dow, 2003; Frank & Gunderson, 1990). However, in concordance with the non-psychotic literature, this early relationship has been found to predict outcome in therapy (Bentall et al., 2003; Frank & Gunderson, 1990; Gehrs & Goering, 1994; Svensson & Hansson, 1999). Studies differ on how much agreement there is between client and therapists' ratings of the therapeutic relationship (Gehrs & Goering, 1994; Svensson & Hansson, 1999) and whether it is the therapist's or the client's rating of the therapeutic relationship which best predicts outcome (e.g. Bentall et al., 2003). Should goals be couched in terms of reducing psychotic symptoms, agreement may be low. But this may not be the case if goals focus on reducing clients' distress. The bond aspect of the working alliance is the slowest to develop with non-psychotic clients and may not be as deep in CBT as it is with other therapeutic approaches (Horvath, 1994). To summarise, by referring to previous research it is not possible to predict the quality of the therapeutic relationship nor the level of agreement between clients and therapists. The level of agreement on goals may be high or low depending on how goals are described and the quality of the bond is expected to be of a poorer quality than with non-psychotic clients.

1.4.2 Client Factors

Gender

Gender has been found to predict outcome in CBT for psychosis, where females are more likely to have a better outcome in terms of psychotic symptoms (Drury et al., 1996). Gender has not been found to predict the quality of the therapeutic relationship with non-psychotic clients (Horvath, 1994) or clients with psychosis (Dow, 2003; Svensson & Hansson, 1999). Therefore, gender may or may not impact on the therapeutic relationship.

Psychotic Symptoms

As described earlier, there are a number of reasons why clients displaying psychotic symptoms might be more likely to form poorer therapeutic relationships, e.g. a lack of agreement on goals and less therapist empathy. Therefore clients who experience hallucinations, delusions, thought disorder and/or bizarre behaviour might be more likely to form poorer therapeutic relationships, feel less understood by their therapists and disagree more with their therapists on therapeutic goals. However, a recent study found no impact for psychotic symptoms on the therapeutic relationship (Dow, 2003). Although the lack of variance in working alliance scores might have accounted for this result, in accordance with these conflicting results it is not possible to predict the effect of psychotic symptoms on the therapeutic relationship.

Symptom Severity

There have been mixed findings for whether symptom severity predicts outcome and/or the quality of the therapeutic relationship in CBT for psychosis. A NICE study in 2003 found that those clients with stable and persistent symptoms did better

in CBT for psychosis. Tarrier et al. (1993) found that clients with psychosis with higher pre-treatment symptom scores improved more, whereas Tarrier et al., (1998) found that those clients with less severe symptoms did better in therapy. These two studies included a number of treatment approaches, one of which was CBT for psychosis. Kuipers et al.'s (1997) randomised control trial of CBT for psychosis found that symptom severity and strength of delusional conviction and preoccupation did not predict outcome. However, Svensson and Hanson's (1999) study of cognitive therapy for psychosis found that clients who reported more severe pre-treatment psychotic symptoms, formed better therapeutic relationships, whereas McCabe and Priebe's (2003) study of psychotic inpatients found that clients who reported less severe psychotic symptoms formed better therapeutic relationships. There are also mixed findings on the impact of symptom severity on the therapeutic relationship in non-psychotic research (Horvath & Bedi, 2002). Therefore, no predictions about the impact of symptom severity on the therapeutic relationship can be made.

Negative Symptoms

Clients with psychosis who presented only with negative symptoms and no positive symptoms were found to respond less well to CBT. It was harder to establish a good therapeutic relationship because these clients were less distressed about their psychotic symptoms and so did not use suggested cognitive-behavioural strategies consistently (Fowler, 1992). Therefore, clients who present with no positive symptoms and only negative symptoms may form poorer quality therapeutic relationships.

Length of Illness

Tarrier et al. (1998) found that shorter duration of illness predicted outcome regardless of the intervention offered. However, Kuipers et al., (1997) found conflicting results for how length of illness affects outcome among different treatment groups and a NICE (2003) study found that clients with persistent symptoms, i.e. longer length of illness, responded better to CBT. The conflicting results on how length of illness predict outcome mean it is difficult to use these results to propose the effect of illness length on the therapeutic relationship. Two studies which investigated this found that there was no effect of illness length on the therapeutic relationship (Dow, 2003; Svensson & Hansson, 1999) and another study found that first episode psychotic clients were less likely to form good therapeutic relationships (Fleishchacker, 2002). Therefore previous research is not able to suggest how length of illness impacts on the therapeutic relationship.

Number of Hospital Admissions

Kuipers et al. (1997) found that psychotic clients with more hospital admissions did better in CBT for psychosis. They hypothesise that more admissions to a psychiatric hospital in the last five years may imply that the psychosis is more unstable and therefore more disruptive to the client. This impairment in functioning may increase the client's motivation for change. An increased motivation for change may enhance the therapeutic relationship because the client is more likely to agree on goals and to carry out the tasks of therapy. In addition to this, they hypothesised that a more unstable psychosis may be more modifiable by cognitive therapy because it is "less entrenched in the belief system".

Other studies of psychotic clients have found that clients with more pre-treatment hospital admissions formed better therapeutic relationships (Allen et al, 1988; Frank & Gunderson, 1990), or that the number of hospital admissions did not impact on the therapeutic relationship (Dow, 2003; Svensson & Hanson,1999). Therefore, conflicting results mean that it is not possible to hypothesis how the number of previous psychiatric hospital admissions may impact on the therapeutic relationship.

Social Contacts and Employment Status

Previous research into Cognitive Therapy for psychosis has found that therapists' view of the therapeutic relationship is related to clients' pre-therapy social relationships and working ability (Svensson & Hansson, 1999). Specifically, those clients who had been working and socialising regularly before starting therapy were more likely to form a good therapeutic relationship. It is hypothesised that clients able to form social relationships are more likely to be able to form a good relationship with their therapist and that clients who are able to work will be more able to work collaboratively with the therapist to form a good therapeutic relationship.

Reaction to Hypothetical Contradiction and Cognitive Insight

In CBT for psychosis studies, clients' response to hypothetical contradiction (RTHC) has been found to predict outcome, i.e. those clients who ignore the relevance of a hypothetical piece of evidence contradicting their belief are more likely to do worse in therapy. It has been suggested that this measures clients' capacity to consider alternative ways of viewing their experiences, a primary task in CBT for psychosis. Therefore, clients who are able to do this are more likely to benefit from therapy.

Similar to RTHC is the concept of cognitive insight. This is the metacognitive process which allows clients to re-evaluate their anomalous experiences and possible misinterpretations, i.e. "distancing, objectivity, perspective, and self-connection" (Beck, Baruch, Balter, Steer & Warman, 2003). This has been found to mediate outcome in CBT for psychosis (Granholm, McQuaid, McClure, Pedrelli & Beck, 2002). In order for a client to be able to re-evaluate their beliefs and experiences, i.e. to carry out the work of CBT for psychosis, it is necessary that the client has some understanding that their difficulties may be as a result of their style of thinking. This could be described as a type of insight. Without these cognitive processes, a person is likely to believe that their experiences and beliefs are real, and that their thinking is rational. Therefore impaired insight contributes to the development of psychotic symptoms.

The current study investigates the early therapeutic relationship when work considering alternative explanations for experiences and symptoms might not yet have been introduced to clients. RTHC and cognitive insight may therefore be less likely to predict the early therapeutic relationship which is measured in this study. As discussed earlier, this is especially true if goals are described in terms of reducing clients' distress rather than psychotic symptoms.

1.4.3 Therapist Factors

Empathy

Empathy is a therapist's ability and willingness to understand the client's thoughts, feelings, and struggles from the client's point of view (Rogers, 1980). Research into the therapeutic relationship in non-psychotic populations suggests that empathy is an

important predictor (Ackerman & Hillsenroth, 2003). It is presumed to build a warm and supporting environment where the client is more able to make changes. Clients with psychosis may previously have found other people, both mental health professionals and the general population, unable to understand the client's perception of their situation, i.e. to have little empathy. This may be because psychotic symptoms and presentations can be very different to the experiences of the general population. A therapist who can go against this norm and display understanding of the client's situation is therefore likely to experience a positive reaction from the client and go on to engender a good bond and therapeutic relationship between themselves and their client. When rating levels of therapist empathy with non-psychotic clients, agreement between clients and therapists is low and it is the clients' ratings which best predicts outcome, both in CBT and non-CBT approaches (Burns & Nolen-Hoeksema, 1992; Free, Green, Grace, Chernus & Whitman, 1985). In summary, if therapists are able to empathise with clients' unusual experiences then levels of therapist empathy may be higher than with non-psychotic clients, but therapists may find this difficult to do. Also, therapist and clients are likely to disagree on the level of therapist empathy, with clients' ratings higher than therapists'.

Expertness, Trustworthiness, Attractiveness

Clients who perceive their therapists to be more expert, trustworthy and attractive have been found to report better therapeutic relationships (Ackerman & Hillsenroth, 2003). It is hypothesised that these factors help clients to be confident in and trust therapists, who can then influence clients in order to help bring about client change.

Experience and Confidence

More experienced therapists are likely to develop better therapeutic relationships for the reason stated above, that clients may have more confidence in them (Ackerman & Hillsenroth, 2003). In particular they are more likely to agree on tasks and to develop a stronger bond. It has been found that therapists who expect therapy to be useful for clients and who expect to feel comfortable in sessions are more likely to develop better therapeutic relationships (Joyce & Piper, 1998). More experienced and confident therapists might expect both of these things and so this may be one way in which they engender confidence in their clients. It has also been found that more experienced therapists are better able to manage their reactions to clients (Brody & Farber, 1996) and are better able to empathise with unusual experiences than to engage in premature cognitive challenging (Burns & Auerbach, 1996). Therapists' confidence in doing therapy has not been researched in relation to the therapeutic relationship. However, it is hypothesised that more confident therapists would make their clients feel confident in them, manage better their reactions to clients, be more empathic and so as a result of all these factors develop better therapeutic relationships.

1.4.4 Matching Client and Therapist Demographics

Age, Gender and Ethnicity

Research with non-psychotic clients suggests that clients and therapists who are more similar in terms of age, gender and ethnicity are more likely to form good therapeutic relationships (Beutler et al., 1991; Fiorentine & Hillhouse, 1999). This may be because clients use basic similarities to judge how well they will be understood by their therapist.

1.4.5 Therapy Factors

Presentation of a Case Formulation

Within CBT approaches, a case formulation is considered essential. It is an individualised understanding of the client's difficulties in the form of a set of hypotheses about the factors which caused, and are maintaining, the difficulties. This allows both the client and therapist to better understand the client's difficulties and to identify areas of possible and meaningful change. From a case formulation it should follow that the client feels more understood by the therapist and also that both therapist and client agree on the goals of therapy and the tasks necessary to achieves such goals. This would therefore enhance the therapeutic relationship. A case formulation is one of the four main components of CBT for psychosis and has been said to reduce distress (John & Turkington, 1996), and to enhance the therapeutic relationship (Fowler, 2000).

One study which looked at the impact of presenting a case formulation on the therapeutic relationship in CBT for psychosis found that the quantitative results indicated no impact of the case formulation on the therapeutic relationship, although in qualitative interviews clients said the case formulation helped increase their understanding and optimism (Chadwick, Williams & Mackenzie, 2003). Furthermore, the therapeutic relationship was measured for only two sessions after presentation of the case formulation and therefore there may not have been sufficient time for the effects to emerge. Therefore, the presentation of a case formulation may be expected to improve the quality of the therapeutic relationship but a number of sessions may be needed before its effects can be observed.

Specific CBT for Psychosis Interventions

Adherence to the therapeutic model, but not the amount of techniques used, has been found to be related to the therapeutic relationship in psychodynamic therapy (Ogrodniczuk & Piper, 1999).

Techniques which convey support, increase the client's understanding of their problems, and increase the level of connection between patient and therapist have been found to help form a good therapeutic relationship (Ackerman & Hillsenroth, 2003). Most of the CBT for psychosis interventions measured in this study fulfil one or more of these functions. Therefore, it might be expected that the more interventions therapists have used, the better the therapeutic relationship, although this is not what previous research into psychodynamic therapy has found.

In summary, findings from different areas of research suggest how specific client, therapist and therapy factors might be expected to predict the therapeutic relationship in CBT for psychosis.

1.5 RATIONALE FOR THE STUDY AND THE RESEARCH QUESTIONS

1.5.1 Rationale for the Study

A significant proportion of patients with psychosis have residual psychotic symptoms and it has been established that CBT for psychosis is successful at reducing these psychotic symptoms and sustaining this reduction over time (Gould et al., 2001). CBT for psychosis aims to do this by helping clients to re-evaluate their experiences and beliefs. In order for this to happen, a good therapeutic relationship must first be established. This can be particularly difficult to do with psychotic

clients, e.g. because clients may be paranoid, and/or therapists may have difficulties understanding clients' experiences. In the literature suggestions have been made with regards to what client, therapist and therapy factors may be important in developing a good therapeutic relationship when doing CBT for psychosis. However, little research has been carried out to date (Alexander & Coffey, 1997; Frank & Gunderson, 1990). At the current time, suggestions made in the literature are based on research into the therapeutic relationship with non-psychotic clients, observations from clinical practice, and theories about psychotic symptoms and their possible effects on the therapeutic relationship.

This study will therefore investigate what client, therapist and therapy factors predict the therapeutic relationship in CBT for psychosis, drawing on previous research to do so, e.g. the therapeutic relationship in non-psychotic populations. Bordin's model and measure of the working alliance will be used because it is pantheoretical and is widely used in the therapeutic relationship literature, allowing direct comparisons between findings.

It is the early therapeutic relationship that has been found to best predict outcome and so this will be studied. Both client and therapist views of the therapeutic relationship will be investigated because there is mixed views in the literature about which best predicts outcome in CBT for psychosis.

1.5.2 The Research Questions

Given the contradictory state of the existing literature, this study will attempt to explore factors associated with a good therapeutic relationship in CBT for psychosis. The main research questions that this study will investigate are:

1. What is the quality of the initial therapeutic relationship between therapists and psychotic clients and how much do clients and therapists agree on the alliance components of tasks, bonds and goals?

2. To what extent is the quality of the therapeutic relationship correlated with each of the following factors:

   a) client factors, such as psychotic symptoms, length of illness, reaction to hypothetical contradiction, and insight.

   b) therapist factors, such as experience, confidence, and the client's view of the therapists' levels of empathy, expertness, trustworthiness, and attractiveness.

   c) client and therapist congruence on demographic variables, such as gender, age, and ethnicity.

   d) therapy factors, such as the presentation of a case formulation.

CHAPTER 2

METHOD

2.1 Overview

The study was a cross-sectional, correlational design with measures taken when clients were between sessions two to nine of CBT for psychosis. Clients and therapists completed questionnaires concerning clients' psychological problems, clients' view of their therapist and the therapeutic relationship, therapists' views of themselves and the therapeutic relationship, and interventions carried out in therapy thus far.

2.2 Participants

In order to obtain 80% power, a sample size of 47 participants was needed to detect a correlation of 0.4 at alpha significance level of 0.05.

Participants were recruited from three sites: an inner London CBT for psychosis clinic (14 participants, 58%), 3 Community Mental Health Teams within inner city London Boroughs (6 participants, 25%), and a London Psychology Service for clients with long-term needs (4 participants, 17%).

Inclusion criteria for clients were: (1) A schizophrenia- or psychosis-related diagnosis, e.g. psychotic illness, schizo-affective disorder; (2) aged between 18 to 65 years old; (3) receiving CBT for psychosis; and (4) sufficient understanding of the English language as to allow understanding and completion of the questionnaires. The exclusion criterion was co-morbidity of substance abuse.

Therapists were approached first. Of the 47 therapists approached, 24 (51%) worked with clients who met the inclusion criteria during the course of the study. Out of these 24 therapists, 17 (36%) worked with clients who agreed to take part. Of those therapists that participated, 5 (29%) were male and 12 (71%) were female; the average age was 31.1 (SD = 3.3, range = 25-38); and all described their ethnicity as White. In terms of profession there were 8 (47%) Clinical Psychologists, 1 (6%) Counselling Psychologist, 7 (41%) Trainee Clinical Psychologists and 1 (6%) Consultant Psychiatrist. The average number of years qualified was 1.6 (SD = 3.3, range = -2.75 to 10 years); therapists had seen on average 9.5 (SD = 8.7, range = 0-30) clients previously for CBT for psychosis; felt on average that their confidence in carrying out CBT for psychosis was 3.7 "somewhat confident" out of a possible 7 (SD = 1.3, range = 2-6) and had on average 1.4 clients in the study (SD = 0.7, range = 1-3).

56 clients fit the inclusion criteria. 7 (12%) dropped out of treatment before they were approached to take part, and 25 (45%) declined to take part. Apart from the above inclusion criteria, no further data is known for those clients. 24 (43%) agreed to participate. Of those that participated, the diagnoses were: 17 (71%) Schizophrenia, 3 (12.5%) Schizoaffective Disorder; 3 (12.5%) Psychotic Illness and 1 (4%) Delusional Disorder. 17 (70%) were male and 7 (30%) were female; the average age was 39.5 (SD = 8.4, range = 20-53); the average length of illness was 16.8 years (SD = 9.3, range = 2-36); 15 (63%) described their ethnicity as White, 7 (29%) as Black, 1 (4%) as Asian, and 1 (4%) as Mixed.

This project was reviewed by Local Research Ethics Committees and registered with Research and Development departments associated with each research site (Appendix 1 & 2).

2.3 Procedure

All therapists working in the research sites agreed to participate in the study. The therapists identified suitable clients and gave these clients the research information sheet. If clients declined to participate, no further contact was made. If clients agreed to participate, an interview with the researcher was arranged. During this interview questionnaires were either completed independently by clients or by the researcher asking questions of the clients. Clients were interviewed once when they were between sessions 2 and 9 of therapy and were reimbursed £10 for their time. Clients were offered the chance to receive feedback from the study when it was completed.

Therapists were sent questionnaires and completed them at the same time-point as their client. Therapists were offered the opportunity to receive feedback from the study when it was completed.

2.4 Measures

2.4.1 Measures Completed by Clients

Client Demographics (Appendix 5)

Items asked about the client's age, gender, ethnicity, diagnosis, current medication, number of psychiatric hospitalisations in the last year and last five years, and age at onset of illness.

Working Alliance Inventory – Client Version (WAIc: Horvath, 1981, Appendix 5)

The WAI measures three components of the therapeutic relationship according to Bordin's (1979) model of the working alliance: (1)bonds – the emotional bond of trust and attachment between client and therapist, (2)goals – the degree of agreement concerning the overall goals of treatment, and (3) tasks – the degree of agreement concerning the tasks relevant for achieving these goals. 36 items, 12 for each component, are rated on a 7-point Likert scale with anchor points (1=never, 7=always), e.g. "My *therapist perceives accurately what my goals are*". By adding together the items, the WAI yields scores for each of these three components from 12 to 36, and an overall score for quality from 36 to 108.

The WAI has good content validity because the items were initially generated by a content analysis of Bordin's theoretical model of the working alliance. A number of independent investigations provide support for the WAI's convergent and divergent validity, e.g. Safran & Wallner (1991), Greenberg & Adler (1989). Reliability estimates range from .84 to .93 with most reported coefficients in the upper range (Horvath, 1994).

Subjective Experience of Negative Symptoms (SENS: Selten, van den Bosch, Omloo-Visser, & Warmerdam, 1993, Appendix 5)

The SENS is based on the Scale for the Assessment of Negative Symptoms (SANS, Andreasen, 1989) and measures the severity and related distress of negative symptoms as perceived by the psychotic client, "T*o initiate activities you must feel motivated – how has this been lately?*" Using the abbreviated version, respondents rate the severity and distress for each of seven negative symptom on an anchored 6-

point Likert scale (1-5) where *5=very much.* Overall scores from 7-35 for the severity and related distress of negative symptoms are calculated by summing together the relevant items.

The SENS has shown high internal consistency and acceptable test-retest reliability (Selten et al., 1993).

Beck Cognitive Insight Scale (BCIS; Beck, Baruch, Balter, Steer & Warman, 2003, Appendix 5)

The BCIS was developed to evaluate patients' self-reflectiveness and their overconfidence in their interpretations of their experiences, e.g. *"my interpretations of my experiences are definitely right"*. A 15-item self-report questionnaire yields a 9-item self-reflectiveness subscale and a 6-item self-certainty subscale. A composite index of the BCIS reflecting cognitive insight is calculated by subtracting the score for the self-certainty scale from that of the self-reflectiveness scale.

The scale demonstrated good convergent, discriminant, and construct validity (Beck et al., 2003). The BCIS composite index showed a significant correlation with being aware of having a mental disorder on the Scale to Assess Unawareness of Mental Disorder (SUMD; Amador, Flaum, Adreasen, Strauss, Yale, et al., 1994) and the self-reflectiveness subscale was significantly correlated with being aware of delusions on the SUMD. The composite index score of the BCIS differentiated inpatients with psychotic diagnoses from inpatients without psychotic diagnoses. Change scores on the BCIS were significantly correlated with change scores on positive and negative symptoms (Granholm et al., 2002).

Counselor Rating Form (Barak & LaCrosse, 1975, Appendix 5)

The CRF measures three attributes of the therapist as viewed by the client: attractiveness, competence, and trustworthiness. 35 items are rated on a 7-point bipolar scale of word pairs of opposing adjectives, e.g. *dependable-undependable, sincere-insincere.*

It has been found to be reliable and valid, e.g. split-half correlation coefficients of between 0.85 and 0.91 for each scale (LaCrosse & Barak, 1976; Barak & Dell, 1977).

Relationship Inventory – Empathy Scale (RI, Barrett-Lennard, 1959, Appendix 5)

The RI was developed to measure five theoretically critical variables of therapist-to-client response, assessed from the perceptions of client or therapist. One such variable is that of the therapist's empathy. This scale is rated both by the client and the therapist. The original 16-item scale was reduced to 8 items for this study. The items are rated on a 6-point Likert scale with anchor points. The total score ranges from –24 to +24.

Gurman (1977) found the empathy scale to have good validity and the alpha coefficients to exceed 0.80.

2.4.2 Measures Completed by the Researcher in the Client Interview

Scale for Assessment of Positive Symptoms (SAPS: Andreasen, 1984, Appendix 5)

The SAPS measures positive symptoms that occur in schizophrenia, including hallucinations, delusions, bizarre behaviour, positive formal thought disorder and

inappropriate affect. The time set covers the month prior to assessment. Items are rated on a 6-point Likert scale from 0-5 with anchored points, where 0 indicates the symptom is not present and 5 indicates the symptoms is severe, e.g. "D*o you ever hear voices or other sounds when no one is around?"* Scores are calculated for individual psychotic symptoms as well as overall ratings of severity of hallucination, delusions, bizarre behaviour, positive formal thought disorder, and inappropriate affect.

The SAPS has been found to have good to excellent levels of interrater reliability, moderate test-retest reliability, high internal consistency, and high predictive validity (e.g. Andreasen et al., 1995a; 1995b; Malla, Norman & Williamson, 1993).

The Psychotic Symptom Rating Scales (PSYRATs: Haddock, McCarron, Tarrier & Faragher, 1999, Appendix 5)

The PSYRATS consists of two scales designed to rate auditory hallucinations and delusions. The auditory hallucinations subscale (AH) has 11 items and is rated on a five-point ordinal scale (0-4). The items include frequency, duration, severity and intensity of distress, controllability loudness, location, negative content, degree of negative content, beliefs about origin of voices and disruption. The delusions subscale (DS) has six items and is also rated on a five-point ordinal scale (0-4). The items include preoccupation, distress, duration, conviction, intensity of distress and disruption.

The scale demonstrated good inter-rater reliability. All AH items except two were found to have an unbiased estimate of reliability about 0.9 and all DS items except

disruption had estimates of reliability above 0.9. In terms of validity, there were specific associations between some items on the PSYRATS and the modified Psychiatric Scale (KGV: Krawiecka, Goldberg & Vaughn, 1977) which is a standardised assessment scale for psychotic patients. The absence of an association between specific dimensions of the PSYRATS and the KGV augments the position that the dimensionality of symptoms provides additional information pertinent to a comprehensive assessment of auditory hallucinations and delusions. The AH and DS items were shown to be independent of each other. The AH produced three factors: 1) distressing negative content; 2) descriptions of voice; and 3) beliefs regarding the origin and attributions of control. The DS scale produced two factors: 1) a cognitive interpretation factor; and 2) an emotional characteristics factor.

Pre-Admission Functioning (PAF; Strauss, Carpenter & Bethesda, 1972, Appendix 5)

The PAF measures patients' functioning prior to assessment. Four items are rated on a five-point ordinal scale (0-4), where 4 represents the highest level of functioning, e.g. *"duration of no hospitalisation for psychiatric disorder"*. The previous month is assessed with regard to social contacts and psychiatric symptoms, and the previous year with regard to employment and use of psychiatric in-patient services. There is no data for its reliability or validity.

Reaction to Hypothetical Contradiction (RTHC; Brett-Jones, Garety & Hemsley, 1987, Appendix 5)

The RTHC measures whether clients are able to consider and assimilate evidence which contradicts their delusional belief(s). Clients are presented with a hypothetical

piece of evidence which contradicts their delusional belief(s). The client's response is rated on a 4 point scale from 0-3 with anchor points according to how the evidence affects their belief, from not at all (3) to dismissing the belief(s) (0).

The measure of accommodation considers the awareness that the subject has of actual occurrences that are contradicting to their belief, and how these affect their belief. Clients are asked if anything has happened to alter their belief in any way over the previous week. This is then categorised according to changes in conviction, content, preoccupation, and interference.

The RTHC has been found to be independent from other measures of delusional ideation, e.g. insight, level of conviction, and to be easy to use (Hurn, Gray & Hughes, 2002).

2.4.3 Measures Completed by Therapists

Therapist Demographics (Appendix 7)

Items measure the therapist's age, gender, ethnicity, number of years as a qualified clinician, number of clients seen for CBT for psychosis, and confidence in using CBT for psychosis.

Working Alliance Inventory – Therapist Version (WAIt: Horvath, 1981, Appendix 7).

The WAI is re-worded for use by therapists. The 36 items yield the same three components of Bonds, Goals and Tasks, and the overall score of quality of the working alliance. It also has good reliability and validity (Horvath, 1994).

Relationship Inventory – Empathy Scale (RI, Barrett-Lennard, 1959, Appendix 7)

The RI is re-worded for use by therapists and measures how empathic therapists believe themselves to have been with their client. The 8 items are rated on the same 6-point Likert Scale and yield a total score of between –24 and +24. It also has good reliability and validity.

Presentation of a Case Formulation Checklist (after Chadwick, Williams & McKenzie, 2003, Appendix 7)

The PCFC measures whether a therapist has presented a case formulation to a client, what components have been included, and which model of psychosis has been used. 14 items are rated either yes or no. The items relate to the components of a case formulation for CBT for psychosis considered important by Chadwick et al. (2003).

Cognitive-Behavioural Therapy for Psychosis Checklist (Garety,2003, Appendix 7)

The CBT for psychosis checklist measures what interventions therapists have carried out in therapy to date. The interventions suggested are based on Fowler, Garety and Kuipers (1995) CBT for psychosis treatment manual. 16 items are rated "yes" or "no" and the total number of interventions calculated.

CHAPTER 3

RESULTS

The descriptive results will be explored first, followed by an examination of the results in relation to the specific research hypotheses.

3.1 Data Checks

Checks were carried out to ensure that the distributions were consistent with the assumptions of multivariate analysis. This involved examining the variables for missing data, normality, outliers and multicollinearity (Tabachnick & Fidell, 1996). Variables that were not normally distributed were transformed. These were: PSYRATS Disruption, number of psychiatric hospital admissions in past 5 years, PAF – Employment Status, CRF – Expertness, Attractiveness, and Trustworthiness, number of previous CBT for psychosis cases, number of years qualified. All of the transformed variables were found to be normally distributed.

3.2 Background Statistics

Table 1 presents all the different types of CBT for psychosis interventions and for each intervention, the percentage of therapists who reported having carried them out to date with their client. Building rapport was the only intervention that all therapists reported having carried out. On average, 6.6 types of intervention had been undertaken out of a possible 15 (SD = 2.5, Range = 2-12).

Table 1 – CBT for Psychosis Interventions

Intervention	Number of Cases	(%)
Building Rapport	24	(100)
Anxiety & Depression – Cognitive Interventions	18	(75)
Assessment of Personal Goals	15	(63)
Assessment of Negative Symptoms	15	(63)
The Role of Medication	15	(63)
Anxiety and Depression – Behavioural Interventions	13	(54)
Personal Model of Individual's Psychosis	10	(42)
Meaning of Psychosis for the Self	9	(38)
Cognitive Therapy for Psychotic Symptoms	9	(38)
Understanding of Most Recent Psychotic Episode	8	(33)
Discussion of Likely Future Course of Psychosis	8	(33)
Promotion of Social Contact and Activity	8	(33)
Relapse – Assessment of Risk and Strategies for	5	(21)
Establishing Contact with Other Agencies	1	(4)
Assessment of and Intervention with Family	1	(4)

N=24

Table 2 presents the possible components of a CBT for psychosis formulation and for each component, the percentage of therapists who reported having included it in the formulation they presented to their client. For 50% of clients, a case formulation had been presented. On average, this occurred in session 4 (SD = 1.7, Range = 2-8) and an average of 5.6 components had been included (SD = 2.1, Range = 3-9).

Table 2 – Components Presented in the Case Formulation

Component	Number of Cases	(%)
Triggers to the current problem	12	(100)
Maintenance factors	11	(92)
Possible targets for therapy	11	(92)
Onset to the problem	8	(67)
Idea that beliefs are not facts	7	(58)
Client's core beliefs	6	(50)
Client's rules for living	6	(50)
Key formative experiences	5	(42)
Possible risks to the therapeutic relationship	1	(8)

Note: The total number of cases in which a formulation was presented was 12.

3.3 Research Question 1

What is the quality of the initial therapeutic relationship between clients and therapists and how much do clients and therapists agree on the quality of the working alliance and its components of tasks, bonds and goals?

Table 3 presents client and therapist WAI scores. The overall scores indicate that on average, both clients and therapists reported that a good therapeutic relationship was present often (5 = often, 6 = very often, 7 = always). Client and therapist scores on the WAI and its components of task and goals were significantly different, with client ratings on average higher than therapists. There was a trend towards client and therapist scores for these three factors being positively correlated. Client and therapist scores on the bond scale were not significantly correlated, although there was a trend towards them being different, with client scores generally higher than therapist scores.

Table 3 – Client and Therapist WAI Scores and Analyses

Component	Client		Therapist		t (23)	p	r	p
Average	Mean	S.D.	Mean	S.D.				
WAI	5.63	.90	5.06	.59	3.60	.002**	.399	.059+
Task	5.73	.87	5.05	.65	3.81	.001**	.364	.095+
Bond	5.54	1.03	5.17	.67	2.05	.052+	.262	.227
Goal	5.62	.87	4.95	.71	3.77	.001**	.361	.091+

** p<.01 N=24
+ trend at p<0.10

3.4 Research Question 2A

To What Extent is the Therapeutic Relationship Correlated with Client Factors?

Table 4 presents all correlational analyses between client factors and WAI scores. No significant correlations were found between client ratings of the working alliance and any of the client factors. There was a trend towards a correlation between therapist ratings of the working alliance and the number of psychiatric in-patient visits in the past 5 years, with therapists rating the working alliance higher when clients had had less visits; and between therapist ratings of the working alliance and the client's level of employment prior to therapy, with therapist rating the working alliance higher when clients had lower levels of employment.

Table 5 presents all t-tests between client factors and WAI scores. There was a significant difference in client ratings of the working alliance for client gender, with female clients' ratings of the working alliance (M=6.29, SD=.36) higher than male clients' (M=5.37, SD=.93), but no other differences on any of the other variables.

Table 4 – Correlations Between Client Factors and WAI Scores

		Client WAI		Therapist WAI	
Measure	**Construct**	**r**	**p**	**r**	**p**
SAPS	Severity of Symptoms	-.211	.322	.151	.482
SAPS	Severity of Hallucinations	-.082	.703	-.077	.722
SAPS	Severity of Delusions	-.044	.838	.307	.144
PSYRATS	Total Severity of Symptoms	-.067	.772	.121	.602
PSYRATAS	Severity of Hallucinations	-.165	.440	-.069	.749
PSYRATS	Severity of Delusions	-.143	.536	.369	.100
PSYRATS	Disruption to Life	-.141	.543	.267	.242
SENS	Negative Symptoms	.019	.939	-.059	.817
SENS	Distress re Neg. Symptoms	-.082	.745	.151	.548
-	Length of Illness	-.116	.589	-.164	.444
-	Inpatient Stays in 5 Years	-.018	.933	-.396	.055+
PAF	Social Contacts	.076	.738	-.030	.900
PAF	Employment	-.036	.867	-.354	.090+
BIS	Cognitive Insight	-.032	.884	-.059	.786

+ trend at p<0.10

N=24

except for PSYRATS where N=21

and SENS where N=18

Table 5 – t-tests Between Client Factors and WAI Scores

		Client WAI		Therapist WAI	
Measure	**Construct**	**t**	**p**	**t**	**p**
Gender		-2.52	.020*	-1.14	.265
SAPS	Hallucinations present?	0.55	.584	0.37	.716
SAPS	Delusions present?	-0.05	.958	-1.47	.157
SAPS	Bizarre Behaviour present?	0.69	.500	-0.81	.429
SAPS	Thought Disorder present?	1.71	.102	0.49	.629
Reaction to Hypothetical Contradiction		0.14	.989	-1.39	.183
RTHC	Accommodation	-0.82	.425	-0.96	.352
-	Inpatient Stays in 1 Year?	-0.14	.893	1.59	.127

* $p<0.05$

N=24

except for RTHC where N=18

3.5 Research Question 2B

To What Extent is the Therapeutic Relationship Correlated with Therapist Factors?

There was a trend towards client and therapist ratings of therapist empathy being positively correlated ($r = .382$, $p = .072$) and they were significantly different ($t(23) = 3.12$, $p = .005$), with client ratings (Mean = 12.5, SD = 7.6) higher than therapist ratings (Mean = 7.6, SD = 5.4).

Significant differences in client ratings of the working alliance were found for therapist gender ($t(22) = -2.86$, $p = .009$), with client ratings of the WAI higher with female (M = 5.90, SD = .79) than male therapists (M = 4.84, SD = .78). Therapist WAI scores were not significantly different for therapist gender ($t(22) = 1.18$, $p = .250$).

Therapist confidence was positively correlated with the number of cases previously seen for CBT for psychosis ($r = .619$, $p = .002$) and also the number of years qualified ($r = .706$, $p = .002$).

Table 6 presents all correlational analyses between therapist factors and WAI scores. Clients rated the working alliance significantly higher when therapists were rated higher on levels of empathy, expertness, attractiveness, and trustworthiness. Therapists rated the working alliance significantly higher when therapist ratings of therapist empathy were higher, and when therapists had seen more clients previously for CBT for psychosis.

Table 6 – Correlations Between Therapist Factors and WAI Scores

		Client WAI		Therapist WAI	
Measure	**Construct**	**r**	**p**	**r**	**p**
RI - client	Therapist Empathy	.640	.001**	.171	.425
RI – therapist	Therapist Empathy	-.047	.829	.475	.019*
CRF	Expertness	.714	.001**	.250	.239
CRF	Attractiveness	.652	.001**	.203	.342
CRF	Trustworthiness	.786	.001**	.296	.161
-	Years Qualified	.018	.944	.293	.254
-	CBT for Psychosis Cases	.091	.686	.464	.030*
-	Confidence in Own Ability	.174	.416	.108	.617

* p<.05, ** p<.01 N=24

except for CBT for psychosis cases where N=23

3.6 Research Question 2C

To What Extent is the Therapeutic Relationship Correlated with Matching Client and Therapist Demographic Variables?

The difference in age between clients and therapists was not significantly correlated with either client WAI scores (r=.101, p=.639) or therapist WAI scores (r=-.211, p=.323).

Table 7 presents all t-test analyses for matching client and therapist demographic variables and WAI scores. There were no significant differences.

Table 7 – t-tests Between Client and Therapist Matching Demographic Variables and WAI Scores

	Client WAI		Therapist WAI	
Construct	**t (22)**	**p**	**t (22)**	**p**
Gender - Client & Therapist the same?	.098	.923	-.019	.985
Ethnicity - Client & Therapist the same?	-.298	.768	.405	.689

N=24

3.7 Research Question 2D

To What Extent is the Therapeutic Relationship Correlated with Therapy Factors?

Table 8 presents all correlational analyses between therapy factors and WAI scores. Client ratings of the working alliance were significantly higher when there had been more types of CBT for psychosis interventions. Therapist ratings of the working alliance were significantly higher when there had been more sessions and there was a trend for the same to be true of client ratings of the working alliance.

Table 8 – Correlations Between Therapy Factors and WAI Scores

	Client WAI		Therapist WAI	
Construct	**r**	**p**	**r**	**p**
Number of Types of Interventions	.468	.021*	.160	.454
Number of sessions	.361	.083+	.470	.021*

* $p<0.05$ N=24

\+ trend at $p<0.10$

There was a significant difference in client ratings of the working alliance for whether a formulation was presented ($t(22) = -2.23$, $p = .036$), with client ratings of the working alliance higher when a formulation had been presented ($M = 6.01$, $SD = .88$) than when it had not ($M = 5.25$, $SD = .79$). There were no significant differences in therapist ratings of the working alliance for whether a formulation was presented ($t(22) = -.764$, $p = .453$).

CHAPTER 4

DISCUSSION

This was a cross-sectional study which aimed to investigate the factors associated with a good therapeutic relationship in CBT for psychosis. This chapter will discuss the results in relation to each of the research questions. The limitations of the study will be considered and the implications of the findings both for further research and clinical services will be put forward.

4.1 Background Information

The patterns of gender, ethnicity and age were different for clients and therapist. All the therapists described their ethnicity as "white" and were more likely to be female and younger than their client. Clients had a mix of ethnicity and were more likely to be male. Therapy was carried out in a variety of services and on average there had been about five therapy sessions prior to the research interview, with a range of two to nine. Engagement with this client group is expected to take up to six sessions and so clients and therapists were in the early phase of building a therapeutic relationship.

4.2 Adherence to the Model

In order to address issues of internal validity, adherence to the CBT for psychosis model was assessed. Therapists were required to report what CBT for psychosis interventions they had carried out in therapy to date and whether they had presented a case formulation. Therapists appeared to be carrying out those interventions expected between sessions two and nine of CBT for psychosis.

Half of the therapists had presented a formulation to their client. This appears to be an appropriate proportion. Assessment and engagement is expected to take up to six sessions with psychotic clients and the presentation of a formulation is carried out soon after this. As clients had attended between two to nine sessions of therapy, it would therefore be expected that some, but not all, would have had a formulation presented to them. Out of a possible nine components to include in a CBT for psychosis formulation as put forward by Chadwick, Williams and Mackenzie (2003), on average therapists included 5.6.

4.3 SUMMARY OF FINDINGS

On average, clients rated the therapeutic relationship higher than therapists although there was a trend towards agreement between clients and therapists on the quality of the therapeutic relationship, i.e. which pairings had better or worse therapeutic relationships.

There were few significant correlations between client factors and the therapeutic relationship. Those factors where there was a trend towards correlation were different for clients' and therapists' reports of the therapeutic relationship. Client ratings of the therapeutic relationship significantly differed according to client gender, where females reported better therapeutic relationships. Surprisingly, many of the factors which might be used to indicate severity of psychosis did not correlate with the therapeutic relationship. Only two client factors correlated with therapist ratings of the therapeutic relationship: the number of previous hospital admissions in the past five years (more admissions = worse relationship) and employment status (more time in employment = worse relationship).

Similar to the therapeutic relationship findings, on average, clients rated therapist empathy higher than therapists, but there was a trend towards clients and therapists agreeing on the level of therapist empathy, i.e. which therapists were more or less empathic. Clients' reports of the therapeutic relationship and therapist empathy were correlated, as were therapists' reports of the therapeutic relationship and therapist empathy. Clients' reports of the therapeutic relationship also correlated with their ratings of therapists' expertness, attractiveness, and trustworthiness but not therapists' reports of their level of past experience and confidence. Therapists' reports of the therapeutic relationship also correlated with the number of cases they had seen previously for CBT for psychosis, but not their confidence or number of years qualified.

No client or therapist matches on demographic variables correlated with, or were significantly different in respects to, the therapeutic relationship, i.e. whether or not clients and therapists were the same or similar in terms of age, gender and ethnicity did not affect reports of the therapeutic relationship.

Both clients and therapists reported better levels of therapeutic relationship when there had been more therapy sessions. Furthermore, clients reported better levels of therapeutic relationship when a formulation had been presented and when more types of CBT for psychosis interventions had been carried out.

4.4 THE QUALITY OF THE THERAPEUTIC RELATIONSHIP

Clients and therapists both reported that good levels of working alliance were often present. Whereas other studies have suggested it may take up to six months to

develop a good therapeutic relationship with clients with psychosis (e.g. Frank & Gunderson, 1990), in this study good levels of therapeutic relationship were reported after only two to nine sessions. These results agree with findings from a recent similar study (Dow, 2003). After only one session of CBT for psychosis good levels of the therapeutic relationship were reported. Taken together, these two more recent studies suggest it is possible to establish a good therapeutic relationship with psychotic clients after only a few sessions.

However, just less than half of the clients asked to take part in the study by their therapists agreed. The others either dropped out of therapy before they were approached to take part or declined to take part. It may be that those clients more likely to drop out of therapy and/or less likely to agree to take part would be those who report lower levels of therapeutic relationship. Therefore the results of this study may be somewhat biased in favour of clients and therapists who had developed good therapeutic relationships.

Therapists reported significantly higher levels of therapeutic relationship when there had been more therapy sessions, and there was a trend for clients to do the same. This suggests that the therapeutic relationship may be developing over the course of a number of sessions. However, as the therapeutic relationship was only measured at one time point this idea cannot be confirmed in the present study. The CBT for psychosis literature suggests that it may take longer to engage psychotic clients and so up to the first six therapy sessions are expected to focus on assessment and engagement (Fowler, Garety & Kuipers, 1995). The results from the present study suggest that this may be the case in routine clinical practice. It would be interesting

to know how many sessions are optimal to reach a good level of therapeutic relationship and whether there is a "window of opportunity" that has already been found for non-psychotic clients (e.g. Mohl et al., 1991; Plotnicov, 1990; Tracey, 1986). Future research where the therapeutic relationship is measured at each session may be able to answer this clinically useful question.

4.4.1 The Level of Agreement Between Clients and Therapists

There was a trend towards client and therapist ratings of the therapeutic relationship being positively correlated, suggesting that to some extent clients and therapists may agree on the quality of the therapeutic relationship. Whereas research with non-psychotic clients has consistently found client and therapist agreement on the quality of the therapeutic relationship to be low (Golden & Robbins, 1990; Horvath & Marx, 1990), this study and others with psychotic populations (e.g. Gehrs & Goering, 1994) suggest that agreement between clients and therapists may be possible.

Although clients and therapists somewhat agreed on the quality of the therapeutic relationship, on average clients rated the therapeutic relationship significantly higher than therapists. Consideration of how clients and therapist make judgements about the therapeutic relationship can help to clarify why there may be this discrepancy. It has been hypothesised (Horvath, 2000) that clients compare the therapeutic relationship to their previous experiences of relationships, as do therapists, who also make more theory-based judgements. Clients with psychosis are likely to have had difficulties in previous relationships, both with mental health professionals and non-professionals, e.g. being disbelieved and challenged. Because of the approach taken in CBT for psychosis, the relationship with their therapist is likely to be more

empathic and accepting and therefore considered better when compared to previous relationships. Therapists are likely to make their judgements of the therapeutic relationship based on experiences with other non-psychotic clients and/or literature about working with clients with psychosis. Therapists may find the development of the therapeutic relationship to be more challenging with psychotic clients, e.g. due to such psychotic symptoms as delusions about the therapist and experiences unusual to the therapist. To compound this, the psychosis literature suggests that the therapeutic relationship will be more difficult to develop with this client group and therapists may be influenced by this suggestion. Indeed, they may assess whether clients are responding like "good" clients (Hersoug, Monsen, Havik & Hoglend, 2000). To summarise, if clients and therapists use previous experiences of relationships and/or theory to judge the therapeutic relationship, clients are more likely to experience the therapeutic relationship as better than previous relationships, whereas therapists are more likely to experience the therapeutic relationship as more difficult. This may explain the finding that clients rate the therapeutic relationship higher than therapists.

There was a trend towards clients and therapists agreeing on the tasks and goals of therapy, but they did not agree on the quality of the bond. Indeed out of the three components of the working alliance, on average clients rated the bond component the lowest whilst therapists rated it higher than tasks or goals. It seems therefore, that clients and therapists have similar experiences in regards to how collaborative the goals and tasks of therapy are, but not in terms of how good the bond between them is. It is expected that the bond will be the component of the therapeutic relationship which takes longest to develop in therapy because it "grows out of the experiences of being associated in a shared activity" (Bordin, 1994). This may be the case for

clients, but not for therapists. For clients who may have had difficult past relationships, trusting the therapist and developing a good relationship may be the more difficult aspect of therapy, whereas for therapists it may be the agreeing on goals and tasks with clients who may have different views about what they need from therapy.

4.5 OVERVIEW OF CLIENT AND THERAPIST FACTORS

4.5.1 Few Significant Findings

Few client and therapist factors correlated with ratings of the therapeutic relationship. This may be explained by a number of reasons. Firstly, the power of the study was low and so relationships between client and therapist factors and the therapeutic relationship may have been missed because related analyses did not reach significance. Secondly, this was an exploratory study where contradictory findings from previous research suggested that factors may or may not correlate with the therapeutic relationship. Thirdly, it may be that the factors chosen to be studied are too broad and so are masking the effects of more specific factors within them. For example, it may be more useful to investigate the effects of different types of delusions, e.g. grandiose or paranoid, on the therapeutic relationship.

4.5.2 The Pattern of Findings

More client factors correlated with therapist than client ratings of the therapeutic relationship and conversely, more therapist factors correlated with client than therapist reports of the therapeutic relationship. This has also been found in research with non-psychotic clients (e.g. Bachelor, 1991; 1995; Lambert & Bergin, 1983). From this, we can conclude that different factors make a good therapeutic

relationship more or less likely for clients and therapists and that therapists' and clients' views of the therapeutic relationship are affected more by factors in the other person than by factors in themselves. Following on from the idea that clients and therapists use previous relationship against which to compare the current therapeutic relationship, then they are likely to compare the current other on the factors measured in this study, e.g. is the current therapist/client more/less empathic than previous people. Both clients and therapists are unlikely to compare themselves with other clients/therapists, as they will have had little experience of other clients/therapists in therapy. This could be investigated in future research.

4.6 CLIENT FACTORS

4.6.1 Factors That Might Indicate Severity Of Illness

Many of those factors which might be used to infer severity of illness did not correlate with reports of the therapeutic relationship, e.g. severity of positive and negative psychotic symptoms, presence or absence of specific psychotic symptoms, level of cognitive insight, reaction to hypothetical contradiction, length of illness. A previous study had similar findings (Dow, 2003). The literature suggests that this should not be the case. Clients who present with more severe psychosis are likely to be more difficult to form a good therapeutic relationship with because of reasons previously discussed.

It was expected that psychotic symptoms may adversely affect clients' views of the therapist, result in more disagreement on the goals and tasks of therapy, result in the client being less able to complete the tasks of therapy, and reduce the ability of the therapist to empathise with the client, thus leading the client to feel less understood. All these factors would result in clients reporting poorer levels of the therapeutic

relationship. Another idea is that clients with no current psychotic symptoms may not engage so well with the tasks of therapy because their symptoms are likely to be having less of an adverse effect on their lives (Fowler, 1992). Therefore, psychotic symptoms have been suggested to lead to both an increase and also a decrease in the quality of the therapeutic relationship. This may explain the lack of effect of psychotic symptoms on clients' reports of the therapeutic relationship. However, this study did not measure overall distress about psychotic symptoms and so it is not possible to assume that those clients with no psychotic symptoms were less distressed than clients with active psychotic symptoms. Where distress was measured in regards to negative symptoms, it did not impact on the quality of the therapeutic relationship.

Two other severity-type factors that may have been expected to impact on the therapeutic relationship are: Reaction to Hypothetical Contradiction (RTHC) and cognitive insight. These constructs are very similar and measure clients' ability to consider alternative ways of viewing their experiences. Both have been found to predict outcome (Kuipers et al., 1997; Granholm et al., 2002), but in the present study did not correlate with reports of the therapeutic relationship. Therefore, the effects of both these factors on outcome may be independent of, and not mediated by their effect on, the therapeutic relationship. It has been suggested that insight allows therapist and client to agree on the goals and tasks of therapy. However, should the goals of therapy be described in terms of reducing the client's distress and not in terms of reducing psychotic symptoms, then cognitive insight may not be necessary for clients and therapists to agree on the goals and early tasks of therapy and therefore, for clients and therapists to form a good early therapeutic relationship.

RTHC and cognitive insight may be more likely to affect clients' ability to engage in the later tasks of therapy such as cognitive challenging of delusions.

Therapists reported higher levels of therapeutic relationship when clients had had fewer psychiatric inpatient visits in the previous five years. Previous research has found mixed results in regards to this and proposed different explanations (e.g. Dow, 2003, Frank & Gunderson, 1990; Svensson & Hansson, 1999). It may be that the number of hospital admissions is an indicator of severity, although the finding that illness severity did not predict the therapeutic relationship in the current study suggests this may be not the case. Alternatively, more hospital admissions might suggest a more unstable and disruptive illness course and therefore an increased client motivation to change and engage in therapy. Further research is needed to explore in what way the amount of previous psychiatric hospital admissions may impact on the therapeutic relationship.

4.6.2 Level of Employment

Therapists reported higher levels of therapeutic relationship when clients were spending less time in some form of employment. Svensson and Hansson (1999) found the opposite to be true. They proposed no theory for why this may be the case. It may be that clients who are employed are likely to be functioning better and are more able to form relationships. Alternatively, it may be that those clients who are not in employment and not functioning so well are more motivated to engage in therapy in order to change their circumstances. Once again, future research needs to focus on explaining how employment status might impact on the therapeutic relationship rather than solely whether or not it does.

4.6.3 Client Gender

The only client factor that correlated with clients' reports of the therapeutic relationship was client gender, with female clients rating the therapeutic relationship higher than male clients. Two previous studies found no effect of client gender on the therapeutic relationship (Dow, 2003; Svensson & Hansson, 1999). Outcome research has found that whether they are receiving treatment as usual or CBT, female clients with psychosis have better outcome than male clients (Peterson, 2000). The current finding suggests that it may possibly be that better outcome is as a result of a good therapeutic relationship formed early in treatment.

Therapists' ratings of the therapeutic relationship did not differ according to the client's gender. Therefore, this is a factor which affects clients' but not therapists' experience of the therapeutic relationship.

4.7 THERAPIST FACTORS

4.7.1 Empathy

Client-rated empathy correlated with the client-rated therapeutic relationship, and therapist-rated empathy correlated with the therapist-rated therapeutic relationship. This suggests that when a therapist was considered empathic, a good therapeutic relationship was formed. There is likely to be somewhat of a halo effect, i.e. measures completed by the same person are more likely to correlate. However, the magnitude of the correlations, large for clients and moderate for therapist, suggests that this finding is more than a halo effect. We can conclude that therapist empathy is considered important in the development of a good therapeutic relationship by both clients and therapists, but particularly by clients. Clients with psychosis are likely to

have had experiences involving other people being unable to empathise with their experiences, beliefs, lifestyle etc. This may explain why clients value an empathic therapist so highly. It should be borne in mind that causation cannot be implied, and it may be that where there is a good therapeutic relationship, the therapist is more likely to be considered empathic.

Rather than therapist empathy resulting in a good therapeutic relationship or vice versa, it may be that these two factors are part of the same construct, that of a therapeutic relationship that includes therapist empathy. Therefore, therapist empathy might be a necessary part of a good therapeutic relationship rather than an independent factor which influences its development.

Although there was a trend towards therapists and clients agreeing on the level of therapist empathy, i.e. which therapists were and were not very empathic, clients were likely to consider the therapist to be more empathic than the therapist believed themself to be. Once again, this result can be explained by considering to whom clients and therapists are comparing the other. Clients are likely to find therapists more empathic than previous people and therapists are likely to find it more difficult to empathise with psychotic clients than other non-psychotic clients.

4.7.2 Expertness, Attractiveness, and Trustworthiness

The results support Strong's (1962) social influence theory that clients who perceive their therapist to be more expert, attractive and trustworthy are more likely to report better therapeutic relationships. There is likely to be a halo effect with these findings, although the correlations are all large, suggesting that there is a link between

expertness, attractiveness, and trustworthiness and clients' reports of the therapeutic relationship.

4.7.3 Experience and Confidence

Therapists who felt more confident in their ability to carry out CBT for psychosis were likely to have had more previous CBT for psychosis cases and to have been qualified for longer. It seems therefore, that the amount of past experience therapists have had affects their confidence in being able to carry out CBT for psychosis.

However, neither therapists' ratings of their confidence in carrying out CBT for psychosis, nor the number of years they had been qualified for, correlated with either client or therapist ratings of the therapeutic relationship. Previous research suggests that clients' perceptions of therapist expertness and confidence are correlated with clients' perception of the therapeutic relationship (Ackerman & Hilsenroth, 2003). Taken together, these findings suggest that it may be clients' and not therapists' perceptions of therapist confidence and experience that affects the therapeutic relationship as perceived by clients and that therapists and clients may differ on how confident they believe the therapist to be. Furthermore, it might be that therapist-perceived general experience and confidence may not affect the therapeutic relationship because other factors such as therapist empathy may impact more on the therapeutic relationship during this early therapy phase of engagement. It is unlikely that a therapist's previous CBT for psychosis experience and length of time post-qualification will affect their capacity to be empathic.

The more clients therapists had seen previously for CBT for psychosis, the higher therapists rated the therapeutic relationship. Therapists who have done more CBT for psychosis may consider themselves more able to form good therapeutic relationships with psychotic clients. Should they be rating the current therapeutic relationship based on previous relationships, if they have had more therapeutic relationships with clients with psychosis then they are also less likely to view the current therapeutic relationship as a lot worse than previous ones.

4.8 CONGRUENCE BETWEEN CLIENT AND THERAPIST DEMOGRAPHIC VARIABLES

None of the therapists and client pairings along lines of age, gender and ethnicity correlated with client or therapist reports of the therapeutic relationship. This suggests that the amount of similarity or dissimilarity between clients and therapists in terms of age, gender and ethnicity does not affect the development of the therapeutic relationship. It may be that these factors are too general to do so.

4.9 THERAPY FACTORS

Clients were more likely to report better levels of the therapeutic relationship when more types of CBT for psychosis interventions had been carried out and when a case formulation had been presented. This suggests that those CBT for psychosis interventions carried out in the early stages of therapy may be doing what they should, i.e. aiding the formation of a good therapeutic relationship.

It is hypothesised that a case formulation results in clients feeling more understood by their therapist, and that clients and therapists are more likely to agree on the goals

and tasks of therapy (e.g. Fowler, 2000). Out of two studies investigating this idea, this is the first study to find a correlation between presentation of a case formulation and the therapeutic relationship. If more types of interventions did lead to a better therapeutic relationship, it may be because the interventions have helped to convey support, to increase the client's understanding of their problems, and to increase the level of connection between client and therapist. All these factors have been found to help form a good therapeutic relationship with non-psychotic clients (Ackerman & Hillsenroth, 2003). It is important to consider the direction of causality and possibility of any third variable affecting this result. It may be that where a good therapeutic relationship has been established, therapists are more likely to present a case formulation and introduce more interventions. Alternatively, a third factor may make it more likely that a better therapeutic relationship is established and so therefore a formulation is presented and/or more interventions are carried out, e.g. clients with less complex presentations. Further research is needed to understand the relationship between presentation of a case formulation, other types of CBT for psychosis interventions, and the therapeutic relationship.

Therapist-rated therapeutic relationship scores did not differ depending on whether or not a case formulation had been presented or whether there had been more types of therapeutic interventions carried suggesting that the benefits of a case formulation and other interventions in terms of the therapeutic relationship are felt by clients and not therapists. It may be that therapists view therapeutic interventions as separate from the therapeutic relationship, whereas clients do not, because the interventions are intended to help clients feel better and reach their goals.

It is recommended, especially with this client group, that the formulation be used to discuss possible risks to the therapeutic relationship, e.g. paranoid beliefs about the therapist and subsequent disengagement from therapy. However, this was the component included the least, indeed by only one therapist. It may be that therapists believe this task to be unnecessary in the early stages of therapy where engagement is paramount and the therapist is working from the client's perspective and so ruptures in the therapeutic relationship may be less likely to occur. However, later on in therapy, collaborative challenging of clients' beliefs may increase the likelihood of such risks occurring and it may be then that a formulation is useful in terms of having a shared understanding of why such risks might occur.

4.10 LIMITATIONS OF THE STUDY

The study had a cross-sectional design, i.e. all measurements were made at one time point. Therefore it is not possible to infer causation from the correlational analyses. At this stage therefore, any causal interpretations are speculative and further longitudinal research is needed to be able to test out some of the ideas proposed.

Although all measurements were taken around the time of early therapy sessions (when clients had received between two and nine sessions) there is the possibility that this difference in the time point in therapy meant different constructs were being measured for different clients, e.g. a very early, as compared to a more developed, therapeutic relationship.

Due to constraints in time and location clients were asked to take part in this study by their therapists. It may be that those clients less likely to agree to take part would be

those who report lower levels of therapeutic relationship. Therefore the results of this study may be somewhat biased in favour of clients and therapists who had developed good therapeutic relationships.

Some of the therapists had more than one client in the study. This reduced the statistical independence and may have biased the findings.

The sample size of 24 means that the study is low in statistical power and that some relationships which may have existed were not detected, i.e. type II errors have occurred. It is therefore important that results approaching significance are considered, as with a more powerful study, they may become significant. However, a large number of analyses were conducted, which means that it is possible that some Type I errors occurred. Since this was an exploratory study, a liberal cut-off value of $p<.05$ was used.

Where constructs were measured by the same people, i.e. client, therapist or researcher, there is the likelihood of a halo effect, i.e. where reporting bias means the measures are more likely to be correlated whether or not the constructs being measured do.

Interpreting the current findings is made more difficult by the lack of theoretical framework available in which to explain them. There is no one coherent theory of how psychotic symptoms and related factors may or may not affect the therapeutic relationship. The CBT for psychosis literature suggests how particular psychotic symptoms may affect the aspects of therapy, e.g. a lack of insight possibly making

agreement on goals more difficult. Other findings have been explained as and when they arise, e.g. more previous hospital admissions may imply that the psychosis is more unstable and disruptive, thus increasing the client's motivation for change and therefore explaining the likelihood of better outcome. The current study, therefore, did not propose a theory to explain how different factors may affect the therapeutic relationship. Instead, its purposes were firstly, to suggest which factors may affect the therapeutic relationship, and secondly, to suggest what hypotheses have already been proposed to explain any such relationships.

4.11 STRENGTHS OF THE STUDY

CBT for psychosis has been found to be an effective intervention (e.g. Gould et al., 2001) for an often severely disadvantaged client group (Bustillo, Lauriello & Keith, 1999). A good therapeutic relationship is considered crucial to successful outcome in therapy and yet to date, little research has been carried out in this area. The current study fills such a gap and provides important information to inform future interventions and research.

The lack of CBT for psychosis being carried out in routine practice has been cited as one reason for the lack of related research (e.g. Dow, 2003). The current study also encountered this difficulty but despite this, 24 client-therapist dyads were recruited from routine clinical practice. Data was collected from client, therapist and researcher at the same time point in therapy, which facilitated important comparisons in viewpoints to be carried out. The study also included measures of treatment adherence, which increased the internal validity of the study. To date, the measurement of treatment adherence in routine clinical practice has been neglected (Startup, Jackson & Pearce, 2002).

CBT for psychosis is a relatively new therapeutic approach. As a result, therapists in research trials are often those who have developed the therapy protocol and/or are experienced in the approach (Cormac, Jones, Campbell et al., 2003; Pilling, Bebbington, Kuipers, Garety et al., 2002). In contrast, the present study had a naturalistic sample of clinicians carrying out CBT for psychosis as part of their everyday clinical practice. Many of the therapists had had little previous experience of carrying out CBT for psychosis, felt only "somewhat confident" in their ability to do so, and on average, had been qualified for only 1.6 years. Therefore, this study provides data on routine clinical practice with less experienced practitioners and where presentations may be more complex than those in controlled research trials.

4.12 CLINICAL IMPLICATIONS

The findings from the current study can be used to guide those therapists carrying out CBT for psychosis. Therapists can be more informed about the likely quality of the therapeutic relationship, how they and their clients might make judgements about the therapeutic relationship, and what factors might or might not affect the quality of the therapeutic relationship. This is important because the quality of the therapeutic relationship has been found to predict outcome (e.g. Bentall et al., 2003; Frank & Gunderson, 1990; Svensson & Hansson, 1999).

4.12.1 The Quality of the Therapeutic Relationship

The results of this and another study (Dow, 2003) suggest it is possible to have good levels of therapeutic relationship early in therapy with clients with psychosis. This finding needs to be reflected in the CBT for psychosis literature in order that therapists are aware that a good therapeutic relationship is not as difficult with

outpatient clients as might be expected. This may lead to increases in optimism and also interest and confidence in learning about and carrying out CBT for psychosis. An increase in therapists carrying out CBT for psychosis is crucial in order to meet a high demand.

It would be useful for therapists to know that clients may perceive the therapeutic relationship to be better than they do. Therapists should therefore not rely solely on their judgements of the therapeutic relationship but should be encouraged to regularly ask clients to feedback about and/or measure the therapeutic relationship. This could be done using the shortened version of the WAI (Tracey & Kokotovic, 1986) which has twelve items and takes only a few minutes to complete. However, it should be borne in mind that clients' reports of the therapeutic relationship may be affected by the knowledge that their therapist will view the results. Therapists subsequent task in therapy is then to continue to negotiate the quality of the therapeutic relationship in order that differences in opinions are identified and discussed (Horvath & Bedi, 2002).

Therapists may also find it helpful to know that they and their clients may be basing their judgements of the current therapeutic relationship on past experiences and/or theoretical understanding. Therapists could consider their past experiences of engaging clients as well as their knowledge and beliefs about psychosis in order to judge how they are likely to assess the current therapeutic relationship. This knowledge, combined with knowledge of clients' previous and current experiences of relationships, may aid the therapist in having an idea of how both themselves and the client are likely to be judging the therapeutic relationship.

4.12.2 The Severity of Psychotic Symptoms – A Factor in Determining Engagement?

Previously it was assumed that psychotic symptoms would make the therapeutic relationship and thus therapy more difficult. In the present study this was not found to be the case. Therefore, the presence and/or severity of psychotic symptoms should be not used as criteria against which to judge the suitability of clients for therapy in terms of engagement, although some factors may later effect clients' ability to undertake therapeutic tasks such as challenging delusions.

The presence of psychotic symptoms may adversely affect the therapeutic relationship for reasons such as an increase in disagreement on goals, or a decrease in therapists' ability to empathise. Conversely, a lack of current positive psychotic symptoms couple with a lack of distress about symptoms may make a poorer quality of therapeutic relationship more likely. Therapists are responsible for assessing individuals clients to determine which of these two scenarios may be applicable and require addressing, e.g. assessment and intervention for motivation, considering collaborative goals.

4.12.3 Factors Which May Affect the Therapeutic Relationship

Therapists who are aware of what factors may increase the likelihood of the formation of a good therapeutic relationship would be able to attempt to include such factors in therapy, e.g. presentation of a formulation, empathy, more interventions, being considered expert, attractive and trustworthy.

Being aware of what factors may make a good therapeutic relationship less likely, e.g. a male client or therapist, would enable therapists to monitor more closely the therapeutic relationship in such cases in order that any problems in the therapeutic relationship be identified and addressed.

For a number of reasons it is also useful for therapists to know what factors have been found not to affect the therapeutic relationship. Clinical Psychologists who carry out the bulk of the CBT for psychosis work in the NHS are, as demonstrated in this study, likely to lack diversity in terms of ethnicity and age, and they tend to be female, whereas their client group are likely to be more diverse in terms of age and ethnicity, and tend to be male. Therefore it is more likely that clients and therapists will not be matched on these demographics. That these "mismatches" do not affect the quality of the therapeutic relationship is therefore encouraging and clinicians and services should not feel the need to match clients and therapists, unless of course clients request so.

4.12.4 Therapist Confidence

Many therapists carrying out CBT for psychosis are likely to have had little previous experience of the model. For example, clinical psychologists working in Community Mental Health Teams will probably have only a few clients on their caseload at any one time that is suitable for this approach. These relatively inexperienced CBT for psychosis therapists may be encouraged to know that although they are likely to feel less confident in their ability, they are no more likely to form a poorer quality early therapeutic relationship. Lack of confidence due to lack of previous experience is therefore not a reason to worry about the early therapeutic relationship.

4.13 FURTHER RESEARCH

Further research could involve taking measurements pre, during, and post-therapy. The benefits of longitudinal research would be multiple. Causation between factors and the therapeutic relationship could be inferred and assessment made of how the therapeutic relationship and its relationship to other factors develop over time and in different stages of therapy. This would be useful in determining whether there is a "window of opportunity" for the development of a good therapeutic relationship and when ruptures in the therapeutic relationship might be more or less likely according to what interventions are being carried out.

To date, research in this area has varied on a number of important factors, e.g. types of location, therapy, clients, therapists and measures of the therapeutic relationship, leading to difficulties making firm conclusions. This study and another recent one (Dow, 2003) have begun the process of making the research more homogenous and therefore comparable and useful, e.g. by investigating outpatient CBT for psychosis in routine clinical practice using the measure of the therapeutic relationship which has the best psychometric data and is most widely used, the WAI. Future studies should continue this approach, as well as including measures of treatment adherence to increase internal validity.

Three studies have found only a few significant correlations between a number of client factors and the therapeutic relationship, suggesting that future research might be more useful in if includes more specific client variables, e.g. different types of delusions and hallucinations.

In addition, more conclusive findings on the relationship of the therapeutic relationship to outcome are crucial. Clients and therapists differed on what factors made a good therapeutic relationship more likely. If it was known whose view of the therapeutic relationship best predicted outcome, then the factors that made this view of the therapeutic relationship more likely to be positive could be emphasised in therapy.

An improved sampling procedure would be one where clients are approached to take part by an independent researcher rather than by their therapist. Clients would be encouraged to take part however they believe their therapeutic relationship to be like, i.e. those possibly with not so good therapeutic relationships would be encouraged to take part.

4.14 CONCLUSIONS

CBT for psychosis is a relatively new and yet effective intervention (e.g. Gould et al., 2001) for an often severely socially disabled client group (Bustillo, Lauriello & Keith, 1999). A good therapeutic relationship is generally considered to be difficult to establish, yet crucial to the work of therapy (e.g. Fowler, Garety & Kuipers, 1995). Little research has been carried out in this important area and the current study is able to suggest that good therapeutic relationships are being established in routine clinical practice. It has also begun the process of investigating what factors might make a good therapeutic relationship more likely and further research is needed to continue this important line of enquiry.

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APPENDIX 1

Local Research Ethics Committees Approval Letters

Institute of Psychiatry

at The Maudsley

Ethical Committee
(Research)
Research Ethics Co-ordinator
Margaret M Chambers Msc

P006, Room W109
De Crespigny Park
Denmark Hill
London SE5 8AF
Tel 020 7848 0797
Fax 020 7848 0147
Email m.chambers@iop.kcl.ac.uk

KING'S College LONDON

University of London

ETHICAL COMMITTEE (RESEARCH)

22 April 2003

Prof D Hemsley
Dept of Psychology
Institute of Psychiatry

Dear Prof Hemsley

Re: What client and therapist factors predict the therapeutic relationship in Cognitive Behaviour Therapy for psychosis? (017/03)

The Ethical Committee (Research) considered and approved the above study at its meeting on 11 April 2003. Please note that this approval is subject to confirmation that the trainee has an honorary contract with the Trust.

Initial approval is given for one year. This will be extended automatically only on completion of annual progress reports on the study when requested by the EC(R). Please note that as Principal Investigator you are responsible for ensuring these reports are sent to us.

Please note that projects which have not commenced within two years of original approval must be re-submitted to the EC(R).

Any serious adverse events which occur in connection with this study should be reported to the Committee using the attached form.

Please quote Study No. 017/03 in all future correspondence.

Yours sincerely,

Margaret M Chambers
Research Ethics Coordinator

Barnet, Enfield & Haringey Local Research Ethics Committee
Holbrook House,
Cockfosters Road,
Barnet EN4 0DR.
Herts.

Tel: 020 8272 5699
Fax: 020 8272 5691
Email: alison.okane@enfield.nhs.uk

28th November 2003

Catherine Evans-Jones,
Trainee Clinical Psychologist,
Psychology Service Block G2,
St. Ann's Hospital,
St. Ann's Road,
London N15 3TH.

Dear Ms. Evans-Jones,

03/132: What client and therapist factors predict the therapeutic relationship in cognitive-behavioural therapy for psychosis?

Acting under delegated authority I write to inform you that the Barnet, Enfield & Haringey LREC sub group considered in full the locality issues relating to the above application at the meeting held on 25th November 2003. The issues reviewed were as follows:

- The suitability of the local researcher
- The appropriateness of the local research environment and facilities
- Any specific issues that may relate to this local community

The LREC members on behalf of the LREC consider the locality issues have been adequately addressed and the proposed research can be conducted within the boundary of this Health Authority.

Please note that this opinion alone does not entitle you to begin research

The Barnet, Enfield & Haringey LREC considers the ethics of proposed research projects and provides advice to NHS bodies under the auspices of which the research is intended to take place. **It is the NHS body, which has the responsibility to decide whether or not the project should go ahead,** taking into account the ethical advice of the LREC. Where these procedures take place on NHS premises or using NHS patients, the researcher must obtain the agreement of local NHS management who will need to be assured that the researcher holds an appropriate NHS contract and that indemnity issues have been adequately addressed.

The following conditions apply to this project:

- The LREC will require a copy of the final report on completion of the project and require details of the progress of the project periodically (i.e. annually for longer projects)

- The committee must receive immediate notification of any adverse or unforeseen circumstances arising out of the project.
- If data is to be stored on a computer in such a way as to make it possible to identify individuals, then the project must be registered under the Data Act 1998. Please consult your department data protection officer for advice.
- Failure to adhere to these conditions set out above will result in the invalidation of this letter of no objection.

I confirm that LRECs are fully compliant with the International Committee on Harmonisation/Good Clinical Practice (ICH) guidelines as they relate to the responsibilities, composition, function operations and records of an Independent Ethics Committee/Independent Review Board.

Please forward any additional information/amendments regarding your study to the LREC Co-ordinator at the above address.

Your application has been given a unique reference number please use it on all correspondence with the LREC.

Yours sincerely

Alison O'Kane
LREC Co-ordinator
Barnet, Enfield & Haringey

APPENDIX 2

Local Research and Development Departments Registration

North Central London
Community Research Consortium

Dr Paul Fox
Research & Development Unit
3rd Floor West Wing
St Pancras Hospital
London
NW1 0PE

29 July 2003

Catherine Evans-Jones
University College London

Dear Catherine

Title: What therapist and client factors predict the therapist relationship in cognitive behavioural therapy for psychosis?

Thank you for registering the above project with us. The form you have completed recognised that you are a Care Trust employee but are **not** conducting your research in services that are the responsibility of the following NHS organisations:

- Camden & Islington Mental Health and Social Care Trust
- Camden PCT
- Islington PCT
- Barnet PCT
- Enfield PCT
- Haringey PCT

However as NHS staff you are reminded that all research you are involved in must be conducted in accordance with the Department of Health Research Governance Framework. I attach a leaflet outlining some of the main issues relating to research governance. Please contact us if you require any further information.

Please note that if in the future you intend to use the patients, staff, premises or other resources of the above listed Trusts you must apply for approval to undertake research using a standard project registration form.

While reviewing the documentation you provided, we noticed the following:

- Your registration form states that you have received LREC favourable opinion from the Institute of Psychiatry ethics committee and Trust Approval from South London and Maudsley NHS Trust. Please could you forward copies of the approval letters from these bodies onto us.

Thank you for registering your project with us. I wish you every success with your research.

Yours sincerely,

Paul Fox
Acting Director of Research and Development

Barnet, Enfield and Haringey NHS
Mental Health NHS Trust

R & D DEPARTMENT
ST. ANN'S HOSPITAL
ST. ANN'S ROAD
LONDON N15 3TH

E-mail: research.department@beh-mht.nhs.uk
Direct Line: 020 8442 6503

13 January, 2004

Dear Ms Evans-Jones,

03/132: What client and therapist factors predict the therapeutic relationship in cognitive-behavioural therapy for psychosis?

I am pleased to note that you have received the favourable opinion of the Local Research Ethics Committee for your study.

All projects must be registered with the Research Department if they use patients, staff, records, facilities or other resources of the Barnet, Enfield and Haringey NHS Mental Health Trust.

The R&D Department on behalf of Barnet, Enfield and Haringey NHS Mental Health Trust is therefore able to grant approval for your research to begin, based on your research application and proposal reviewed by the LREC sub group. Please note this is subject to any conditions set out in their letter dated 28 November 2003.

You are obliged to adhere to the research governance framework as set out by the Department of Health Research Governance Framework for Health and Social Care*.

It is required that all researchers submit a report and copies of all publications emanating from the study to the R&D Department. Furthermore, all publications must contain the following acknowledgement.

"This work was undertaken with the support of Barnet, Enfield and Haringey NHS Mental Health Trust, who received "funding" from the NHS Executive; the views expressed in this publication are those of the authors and not necessarily those of the NHS Executive".

"a proportion of funding" where the research is also supported by an external funding body; "funding" where no external funding has been obtained.

Best wishes, and look forward to receiving your report.

Yours sincerely,

*Further information on research governance can be obtained on the DH web pages at http://www.doh.gov.uk/research/

APPENDIX 3

Data Protection Registration

UNIVERSITY COLLEGE LONDON
ESTATES AND FACILITIES DIVISION
RECORDS OFFICE
FACILITIES SERVICES
Gower Street, London WC1E 6BT

Tel 020 7679 7783
Fax 020 7419 2810

7 October 2003

Ms Catherine Evans-Jones,
Sub-department of Clinical Health Psychology,
Department of Psychology
University of London
Gower Street
London
WC1E 6BT

Dear Ms Evans-Jones,

Data Protection Registration

Thank you for your application for Data Protection Registration for your Project: "What client & Therapist factors predict the Therapeutic Relationship in CBT for Psychosis".

I am pleased to confirm that your Research Project will be covered by the UCL Data Protection Registration, reference no. Z6364106, Section 19 Research: Health Research.

Yours sincerely

Mrs. R.H. Cummings,
Records Manager and Data Protection Officer.

APPENDIX 4

Client Consent Form

Information and Consent Form for Participants

Title of the study: What client and therapist factors predict the therapeutic relationship in Cognitive Behavioural Therapy?

Researcher: Catherine Evans-Jones, Trainee Clinical Psychologist, University College London.

Supervisor: Dr Emmanuelle Peters, Clinical Psychologist and Lecturer at the Institute of Psychiatry.

Address: Sub-Department of Clinical Health Psychology, University College London, Gower Street, London WC1E 6BT.

Telephone:

You are invited to take part in this study, which is to be part of the Doctorate in Clinical Psychology training course at UCL being undertaken by Catherine Evans-Jones.

Aim:
The aim of this study is to investigate what characteristics of clients and therapists affect the therapeutic relationship that develops between clients and therapist.

It is hoped that the results of this study will contribute to a better understanding of what characteristics may make a successful therapist-patient relationship more likely. This information can then be used to aid future clients and therapists develop good therapeutic relationships and so gain more from therapy.

What it involves:
The study takes between half an hour and an hour for each participant. You will be paid £10 for your time and expenses will be reimbursed. You will be interviewed about your views on your therapist, your views on the therapeutic relationship between you and your therapist, and the current status of your health. You will be asked to complete some questionnaires about these issues.

Your therapist will also be sent a number of questionnaires regarding their views of their therapeutic relationship with you, and what work they have done in therapy with you.

Some general information will be obtained from the clinic, such as your date of birth, ethnicity, contact with services and diagnoses.

Nothing you say will be disclosed to your therapist and taking part will not affect your therapy in any way.

Voluntary Participation:
You do not have to take part in this study. If you decide to take part you may later on withdraw at any time without giving a reason. Withdrawal from the study will not affect your treatment. Your decision whether to take part or not will not affect you

medical care or treatment in any way. The information obtained from this study will be kept confidential. However, I have a duty of care to inform medical staff if at any time during the study information is obtained that would suggest that you or any other person is in danger. I would not inform medical staff without informing you first.

Ethical Approval:
All proposals for research using human subjects are reviewed by an ethics committee before they can proceed. This proposal was reviewed by the ethics committee of the South London and Maudsley NHS Trust.

To be completed by the participant: **Delete as necessary:**

1. I have a copy of the "Information and Consent Form for Participants" and have read and understood it. Yes / No

2. I have had the opportunity to ask any questions and have received satisfactory answers. Yes / No

3. I understand that participation in this study is voluntary and I am free to withdraw at any time without giving any reason for withdrawing and without affecting my future care. Yes / No

4. I understand that the information obtained from this study will be kept strictly confidential. However, if at any time during the study, information is obtained which would suggest that I or any other person is in danger, the researcher would have the responsibility to inform a member of the medical staff. The researcher would not do that without informing me first. Yes / No

5. I agree to take part in the study. Yes / No

....
(signature of participant) (date)

.....
(printed name of participant)

....
(signature of researcher) (date)

.....
(printed name of researcher)

Thank you for your co-operation

APPENDIX 5

Client Measures

Client Demographics

Working Alliance Inventory – Client Version (WAIc)

Scale for the Assessment of Positive Symptoms (SAPS)

The Psychotic Symptom Rating Scales (PSYRATS)

Subjective Experience of Negative Symptoms (SENS)

Pre-Admission Functioning (PAF)

Beck Cognitive Insight Scale (BCIS)

Reaction to Hypothetical Contradiction (RTHC)

Counselor Rating Form (CRF)

Relationship Inventory – Client Version (RI)

Code: .....
Date: .....

Please fill in the following information:

Age: .....

Gender: .....

Ethnicity: .....

Age at onset of illness: .....

Number of visits to a psychiatric hospital in the last year: .....

Number of visits to a psychiatric hospital in the last 5 years: .....

SCALE FOR THE ASSESSMENT OF POSITIVE SYMPTOMS

APPENDIX 7

Therapist Measures

Therapist Demographics

Working Alliance Inventory – Therapist Version (WAIt)

Relationship Inventory – Therapist Version (RI)

Presentation of a Case Formulation Checklist (PCFC)

Cognitive-Behavioural Therapy for Psychosis Checklist

Code: .....
Date: .....

Please fill in the following information about YOURSELF:

Age: .....

Gender: .....

Ethnicity: .....

How many years have you worked as a qualified clinician? .....

Approximately how many people have you seen for CBT for psychosis? .....

How confident are you in using cognitive behavioural therapy for psychosis?

1	2	3	4	5	6	7
not confident at all		**somewhat confident**		**quite confident**		**extremely confident**

Code: .....
Date: .....

Below are listed a variety of ways that one person may feel or behave in relation to another person.

Please consider each statement with reference to your present relationship with your client, ...

Mark each statement in the left margin, according to how strongly you feel that it is true, or not true, in this relationship. Please mark every one. Write in +3 +2 +1 or -1 -2 -3, to stand for the following answers:

+3	*Yes, I feel strongly that it is true*	*-1*	*no, I feel that it is probably untrue, or more untrue than true*
+2	*Yes I feel it is true*	*-2*	*No, I feel it is not true*
+1	*Yes, I feel that it is probably true, no more true than untrue*	*-3*	*No, I strongly feel that it is not true*

..... 1. I want to understand how he see things

..... 2. I understand his words but do not know how he actually feels.

..... 3. I looks at what he does from my own point of view.

..... 4. I can tell what he means, even when he has difficulty in saying it.

..... 5. I usually understands the whole of what he means.

..... 6. I ignore some of his feelings.

..... 7. I appreciate just how his experiences feel to him.

..... 8. At the time I don't realise how sensitive or touchy he is about some of the things we discuss.

Code: .....
Date: .....

Below are listed a variety of ways that one person may feel or behave in relation to another person.

Please consider each statement with reference to your present relationship with your client, ...

Mark each statement in the left margin, according to how strongly you feel that it is true, or not true, in this relationship. Please mark every one. Write in +3 +2 +1 or -1 -2 -3, to stand for the following answers:

+3	*Yes, I feel strongly that it is true*	*-1*	*no, I feel that it is probably untrue, or more untrue than true*
+2	*Yes I feel it is true*	*-2*	*No, I feel it is not true*
+1	*Yes, I feel that it is probably true, no more true than untrue*	*-3*	*No, I strongly feel that it is not true*

..... 1. I want to understand how she see things

..... 2. I understand her words but do not know how she actually feels.

..... 3. I looks at what she does from my own point of view.

..... 4. I can tell what she means, even when she has difficulty in saying it.

..... 5. I usually understands the whole of what she means.

..... 6. I ignore some of her feelings.

..... 7. I appreciate just how her experiences feel to her.

..... 8. At the time I don't realise how sensitive or touchy she is about some of the things we discuss.

Code: .....
Date: .....

Presentation of a Case Formulation Checklist

To be completed by the therapist: **Delete as appropriate:**

1. During your sessions to date, have you presented a case formulation to the client? Yes / No

2. In which session(s) did this occur? .....

3. If "yes": In the formulation, have you included:

a. An analysis of the maintenance of current psychotic and non psychotic problems (links between thoughts, feelings, behaviour, and physical signs)? Yes / No

b. Triggers to the current problem (internal or external)? Yes / No

c. The onset of the problem (critical incidents)? Yes / No

d. The client's rules for living (dysfunctional assumptions and behaviour implications)? Yes / No

e. The client's core beliefs (self, others, world and future) and/or issues about self-esteem? Yes / No

f. Key formative experiences? Yes / No

g. Possible targets for therapy? Yes / No

h. The idea that the client's beliefs are not facts, but reactions to, and ways of making sense of, their experiences? Yes / No

i. Possible risks to the therapeutic relationship based on the case formulation? (e.g. mistrust) Yes / No

4. Have you presented the stress-vulnerability model of psychosis? Yes / No

5. If not, have you presented another "illness" model? Please specify..... Yes / No

6. Please add any further comments:

Code: .....

Date: .....

CBT for Psychosis Checklist

Below is a list of interventions commonly used in CBT for psychosis. In your work with your client so far, please could you state whether or not you have undertaken each intervention. Do this by placing a tick in the box next to these interventions. At this stage in therapy, it is expected that you won't have done a number of these interventions. However, we are interested in any that you have carried out.

Activity	Yes or No
1. Establishment of rapport and trust, initial assessment of subjectivity defined problems and development of agreed preliminary goals for therapy	
2. The collaborative development of a detailed understanding of the most recent psychotic episode	
3. Developing a personal model of the individual's psychosis, taking account of the person's own history, vulnerability factors, personal stresses and triggers for psychotic episodes.	
4. Detailed assessment of and cognitive therapy for any enduring psychotic symptoms or unusual perceptual experiences (which includes copying work and CT for delusional beliefs/appraisals of hallucinations)	
5. A consideration of the meaning of the psychosis for the self-How does having had psychotic episode(s) affect the view the person takes of the self, may include discussion of issues of stigma, control over life	
6. A discussion of the future likely course of the psychosis and the implications of this for engaging in services and specialist mental health supports.	
7. The person's evaluation of the role of medication (and concerns such as dependence, side-effects) discussion of costs and benefits of medication and encouragement, where appropriate, to adhere to medication prescribed and/or to negotiate changes with psychiatrist.	
8. An evaluation of levels of self-esteem and negative self-evaluations, depression and anxiety with cognitive work as appropriate.	
9. A specific assessment of the risk of relapse, personal relapse signatures and developing strategies for responding to early warnings of relapse.	
10. The assessment of the individual's personal goals with particular reference to work/education and personal relationships, considering both short-term and long-term goals, linking as appropriate to relevant services.	
11. Assessment of negative symptoms-social withdrawal, anhedonia, ill-defined subjective sense of difference/lack of energy/lack of contact.	
12. Activity scheduling or engagement with family or agencies to promote graded social contact and activity.	
13. Behavioural techniques for reducing anxiety or depression (eg graded exposure, relaxation, distraction, self-talk.	
14. Establishing contact with other agencies, eg CMHTs, vocational programmes, voluntary programmes to promote social, occupational or other functioning.	
15. Assessment of family needs and brief family intervention (information about psychosis, promoting understanding, discussion of strategies for specific problems).	
16. Other (please specify)	
17. No active interventions (give reasons)	